

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12839

12861

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 41			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Laurel Hospital				d. STREET ADDRESS Box. 212 A Gorman Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD First KIRBY Middle ALLEN Last				4. DATE OF DEATH Month November Day 10 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 Oct. 1959	
9. AGE (In years last birthday) yrs. 1 Months 7		IF UNDER 1 YEAR Hours 7 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel A. Allen				14. MOTHER'S MAIDEN NAME Joan A. Knowski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Daniel A. Allen (Father) Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 10, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		11/12/59		Carver Memorial Park		Mount Airy Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS De W. L. Randall, Laurel, Md.				24a. REC'D BY REGISTRAR DATE NOV 13 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12862

CERTIFICATE OF DEATH

Reg. Dist. No.

12840

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle Attick Last Attick		4. DATE OF DEATH Month November Day 12 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-89
9. AGE (In years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME George W Bursey		14. MOTHER'S MAIDEN NAME Mary K Cloud	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. CAUSE OF DEATH [Enter only one cause per line (for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Cerebral Calcifications Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 yr +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 , 19 NOV , 19 59 , that I last saw the deceased alive on 11/12 , 19 59 , and that death occurred at 6:30 M, from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Etienne M.D. 4713 - Berwyn Rd DATE SIGNED PHYSICIAN'S NAME (Type) Dr. Etienne College Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 16, 1959	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR DATE NOV 17 '59	
24b. REGISTRAR'S SIGNATURE Charles E. Hines			

12840

CERTIFICATE OF DEATH

12840

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 15, 1900*

5. Date of death: *Dec 10, 1945*

6. Place of death: *Home*

7. Cause of death: *Heart Disease*

8. Signature of physician: *[Signature]*

9. Signature of registrar: *[Signature]*

10. Date of registration: *Dec 15, 1945*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12841

Reg. Dist. No.

12923

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>her. Touring Office</u>				d. STREET ADDRESS <u>1760 Atwood Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Irving Bagent</u>				4. DATE OF DEATH <u>Nov 20 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 19, 1956</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>3</u> Min. <u>3</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-6</u>			
13. FATHER'S NAME <u>William Bruscoe Bagent</u>				14. MOTHER'S MAIDEN NAME <u>Mary Windsor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mary Bagent, same as #2</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO <u>754.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital heart disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Nov 20, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov 23 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SUITHLAND MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>517-11th St. SE Wash, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasa</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12863

CERTIFICATE OF DEATH

12842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P. G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leand Memorial</u>				d. STREET ADDRESS <u>14509 Riverdale Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Virgil</u> Middle <u>G.</u> Last <u>Baldwin</u>				4. DATE OF DEATH Month <u>11-6-59</u> Day <u>19</u> Year <u>19</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 11, 1890</u>		9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Heating</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Drury Baldwin</u>				14. MOTHER'S MAIDEN NAME <u>Sue MILLIGAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-07-1141</u>		17. INFORMANT <u>(son) Russell Y.</u> Address <u>same.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 day</u> <u>5 mo</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Aug. 1, 1930</u> , to <u>Nov 6, 1959</u> , that I last saw the deceased alive on <u>Nov 5, 1959</u> , and that death occurred at <u>1239</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edgar E. Quayle</u> M.D. <u>1822 Biltmore St NW</u> PHYSICIAN'S NAME (Type) <u>Edgar E. Quayle</u> <u>Washington D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft L. ncoln</u>		22d. LOCATION (City, town, or county) (State) <u>Vladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

12864

12843

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tanier</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Tanier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>421 Pr. Georges St</u>		d. STREET ADDRESS <u>421 Pr. Georges St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bossig Burns Beall</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 10, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles S. Burns</u>		14. MOTHER'S MARDEN NAME <u>Louise Haslop</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. E. Beall, 421 Pr. Georges St. Tanier Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Breast</u> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 15, 1949</u> to <u>November 3, 1959</u> , that I last saw the deceased alive on <u>November 2, 1959</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert S. McCenay</u> M.D.		ADDRESS (Street, city or town, state) <u>402 Main St.</u>	
PHYSICIAN'S NAME (Type) <u>Robert S. McCenay</u>		DATE SIGNED <u>Laurel, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Haslop Family Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. McDonald</u> ADDRESS <u>Laurel, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 9 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

248-0101-114

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. RACE [Faint text]</p>	
<p>5. DATE OF BIRTH [Faint text]</p>		<p>6. PLACE OF BIRTH [Faint text]</p>	
<p>7. DATE OF DEATH [Faint text]</p>		<p>8. PLACE OF DEATH [Faint text]</p>	
<p>9. CAUSE OF DEATH [Faint text]</p>		<p>10. MANNER OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12924

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale</u>		c. LENGTH OF STAY IN 1b <u>50 yrs +</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) * <u>Glenn Dale</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bell Station Road</u>				d. STREET ADDRESS <u>Bell Station Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Beall</u> Last <u>Beall</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-1879</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William J Beall</u>				14. MOTHER'S MAIDEN NAME <u>Walter Amanda Beall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Viola C Beall - Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Acute congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov-17-1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Collington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Funn</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12853

CERTIFICATE OF DEATH

Reg. Dist. No. 12845

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Thontg.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 1556-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pine Branch Nursing Home</u>		d. STREET ADDRESS <u>4718 GLENOAK RD</u>	
3. NAME OF DECEASED (Type or print) <u>AUGUST H BECKER</u>		4. DATE OF DEATH <u>11-19-1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 26, 1867</u> 9. AGE (In years last birthday) <u>92</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TAILOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TAILOR</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August H. Becker</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Julius T. Becker Rt 1 Anandale Va</u>	
17. INFORMANT <u>Julius T. Becker</u> Address <u>Box 706</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY INSUFFICIENCY</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-27</u> , 19 <u>51</u> , to <u>11-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-19</u> , 19 <u>59</u> , and that death occurred at <u>4:50</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>R. C. Kirchner</u>		ADDRESS (Street, city or town, state) <u>6480 N.H. AVE - TAKOMA PARK MD.</u> DATE SIGNED <u>11/19/59</u>	
PHYSICIAN'S NAME (Type) <u>R. C. KIRCHNER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u> ADDRESS <u>4812 Laque new Wash DC</u>		24a. REC'D BY REGISTRAR <u>NOV 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

11

1. NAME OF DECEASED JAMES H. WHITE		2. SEX Male	
3. AGE 42		4. DATE OF DEATH April 15, 1922	
5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease	
7. DISEASE OR INJURY Coronary Artery Disease		8. OCCASION OF DEATH Sudden	
9. SIGNATURE OF PHYSICIAN J. H. Smith		10. SIGNATURE OF WITNESSES J. H. Smith, J. H. White	
11. SIGNATURE OF REGISTRAR J. H. Smith		12. SIGNATURE OF CLERK J. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shows, is detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12865

CERTIFICATE OF DEATH

12846

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY FAIRFAX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL	c. LENGTH OF STAY IN 1b adm. 9-22-59	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRFAX CHURCH 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM	d. STREET ADDRESS 918 SPRING LANE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle D. Last BEER		4. DATE OF DEATH Month 11 Day 26 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-23-1884
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GEN. EMPLOYEE		9b. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GEN. EMPLOYEE		10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. DEER		14. MOTHER'S MAIDEN NAME MARY L. YOUNG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records LAUREL SANITARIUM		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY congestion (522) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease (420) DUE TO (c) several yrs?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Dementia (arteriosclerotic) tumor of parathyroid (left)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-22-1959 to 11-26-1959 , that I last saw the deceased alive on 11-26-1959 , and that death occurred at 4:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lillian P. Williams		M.D. LAUREL SANITARIUM 11-26-59	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		LAUREL MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/26/59	
22c. NAME OF CEMETERY OR CREMATORY COLUMBIA GARDENS		22d. LOCATION (City, town, or county) (State) ARLINGTON TOW. VA	
23. FUNERAL DIRECTOR'S SIGNATURE Carl Jenkins		ADDRESS 3524 COLUMBIA PIKE	
24a. REC'D BY REGISTRAR NOV 30 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

12925

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN 1b 47x.3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS 1104 MISSISSIPPI AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Herb Middle ern Last Female BESOSA				4. DATE OF DEATH Month November Day 28 Year 1959			
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Nov. 1959	9. AGE (In years last birthday) Newborn yrs.	IF UNDER 1 YEAR Months 1 Days 45	IF UNDER 24 HRS. Hours 1 Min. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JORGE BESOSA RAMIREZ				14. MOTHER'S MAIDEN NAME DOROTHY CARTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		INFORMANT FROM CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 773.5 DUE TO Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Prematurity DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 1 hr 45 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 28 Nov 1959 to 28 Nov 1959 , that I last saw the deceased alive on 28 November 1959 , and that death occurred at 2 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George E Randall		M.D. USAF HOSPITAL ANDREWS		ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS, ANDREWS AFB, MD		DATE SIGNED 28 Nov 59	
PHYSICIAN'S NAME (Type) GEORGE E RANDALL, CAPT, USAF, MC		PHYSICIAN'S ADDRESS USAF HOSPITAL ANDREWS, ANDREWS AFB, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 30 NOV 59		22c. NAME OF CEMETERY OR CREMATORY DC MORGUE		22d. LOCATION (City, town, or county) (State) WASHINGTON D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 1 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

12866

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 13 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION General Prince Georges General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Bertie Middle Delphia Last Bolithe			4. DATE OF DEATH Month Nov Day 30 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Nov 1887	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Rheuben Nazelrod		
14. MOTHER'S MAIDEN NAME Eliza Sager			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. ---			17. INFORMANT Mrs. Margie Sweeney--- Hall, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Failure DUE TO (c) CVA due to Arteriosclerotic Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) (a) 1 wk INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 wk 12 yrs					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Nov 17 , 19 59 , to 30 Nov , 19 59 , that I last saw the deceased alive on 29 Nov , 19 59 , and that death occurred at 12, 20 AM from the causes and on the date stated above.					
ACTUAL SIGNATURE Dr. Robert Sasscer.		M.D. Upper Marlboro, Md		DATE SIGNED 30 Nov 59	
PHYSICIAN'S NAME (Type) Dr. Robert Sasscer., Upper Marlboro., Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/59		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.	
22d. LOCATION (City, town, or county)		(State)			
Ft. Myer		Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thomas		ADDRESS Upper Marlboro.		24a. REC'D BY REGISTRAR DEC 7 '59	
24b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1988

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *78*
4. Date of birth: *1910-01-01*
5. Date of death: *1988-01-01*
6. Place of death: *New York, NY*
7. Cause of death: *Heart failure*
8. Signature of physician: *Dr. John Doe*
9. Signature of registrar: *John Doe*
10. Date of registration: *1988-01-01*

12867

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE (Washington D.C.) b. COUNTY Prince George-Md. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Washington, D.C.) Parkland, Maryland d. STREET ADDRESS 19 Maryland Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George B Boniface				4. DATE OF DEATH Month Day Year Nov. 19 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-31-10	
9. AGE (In years by birthday) yrs. 49		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dep't. of Defense				10b. KIND OF BUSINESS OR INDUSTRY Missel Research		11. BIRTHPLACE (State or foreign country) Charleston, S. Carolina	
13. FATHER'S NAME Edward Victor Boniface				14. MOTHER'S MAIDEN NAME Margaret G. Madden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 Cirrhosis of liver, esophageal hemorrhage DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) ---				(County) ---		(State) ---	
21. I certify that I attended the deceased from Nov 16 , 19 59 to Nov 19 , 19 59 , that I last saw the deceased alive on Nov 19 , 19 59 , and that death occurred at 10:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald W. Mitchell				ADDRESS (Street, city or town, state) 1746 R St NW Wash DC			
PHYSICIAN'S NAME (Type) Dr. Donald W. Mitchell				DATE SIGNED 11/19/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-59		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryah, Inc.				ADDRESS 317 Pa. Ave., SE DC		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15250

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

CERTIFICATE OF DEATH

15250

1. Name of deceased: _____

2. Sex: _____

3. Race: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b 39 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle Boone Last Boone		4. DATE OF DEATH Month Nov Day 25 Year 1959	
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 AUG 1959
9. AGE (In years last birthday) yrs. 4		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Boone		14. MOTHER'S MAIDEN NAME BARBARA OWENS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT FATHER		Address Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL Polycystic Kidneys 757.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:00A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3001 Chesverly Ave Chesverly, Md. DATE SIGNED ACTUAL SIGNATURE Dr. B. Van Gelderen ., M.D. PHYSICIAN'S NAME (Type) Dr. B. Van Gelderen ., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-28-59	
22c. NAME OF CEMETERY OR CREMATORY Mount Carmel		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Angela R. Sollins		24a. REC'D BY REGISTRAR NOV 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kiang			

2077193XV2

CERTIFICATE OF DEATH

1938

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Race</p>	
<p>4. Date of birth</p>		<p>5. Date of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>		<p>9. Signature of physician</p>	
<p>10. Signature of registrar</p>		<p>11. Signature of informant</p>		<p>12. Date of filing</p>	

12869

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital			d. STREET ADDRESS / 5002-47th. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle A. Last Brown.			4. DATE OF DEATH Month Nov. Day 7 Year 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-68		9. AGE (In years last birthday) yrs. 91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Houses		11. BIRTHPLACE (State or foreign country) D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Brown			14. MOTHER'S MAIDEN NAME Sarah Daugherty		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Elizabeth Vermillion Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia right lung 733X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture left hip. Pathological DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 11-3-59 10-17-59					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) moving back + fell in bed, pathologic			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10-17 19 59 p.m. 10-17 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) (County) (State) Edmonston Prince Georges Md.					
21. I certify that I attended the deceased from 10-17 , 19 59 , to 11-7 , 19 59 , that I lost saw the deceased alive on 11-7 , 19 59 , and that death occurred at 12:19p M, from the causes and on the date stated above.					
ACTUAL SIGNATURE George H. Hagge M.D. 3717-38th St				DATE SIGNED 11-7-59	
PHYSICIAN'S NAME (Type) Dr. G. Hagge					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/59		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 10 1959	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12852

CERTIFICATE OF DEATH

Reg. Dist. No.

12870

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Heverly c. LENGTH OF STAY IN lb 20 min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		2. USUAL RESIDENCE of deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights d. STREET ADDRESS 908-64th Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosa Middle G. Last Brown		4. DATE OF DEATH Month Nov. Day 28 Year 59	
5. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-16
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	11. IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James H. Brown		14. MOTHER'S MAIDEN NAME Emma L. Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 6801	
17. INFORMANT Marie Tilghman-sister		Address 6801 Walker mill Road, S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO B. broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 28 , 19 59 to Nov. 28 , 19 59 , that I last saw the deceased alive on Nov. 28 , 19 59 , and that death occurred at 9:10 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ronald S. Fleischer M.D.		DATE SIGNED 12/29/59	
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER		ADDRESS (Street, city or town, state) 1732 W. W. Chapel Rd. Wash DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-2-59	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY mt Olivet	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington ADDRESS 467 N st NW		24a. REC'D BY REGISTRAR DEC 4 '59 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

1-28-58

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

12870

3

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Signature of informant: _____

13. Name of informant: _____

14. Address of informant: _____

15. Date of filing: _____

16. File number: _____

17. County: _____

18. State: _____

19. City: _____

20. Zip: _____

21. Telephone: _____

22. Fax: _____

23. E-mail: _____

24. Internet: _____

25. Other: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12871

CERTIFICATE OF DEATH

12853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Bryant Last Bryant				4. DATE OF DEATH Month Nov. Day 11 Year 19 59			
5. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Lewis				14. MOTHER'S MAIDEN NAME Louise Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		INFORMANT Address Thase Hunt 6204 L St N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, acute 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Diabetes mellitus DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 4 , 19 59 , to Nov. 11 , 19 59 , that I last saw the deceased alive on November 11 , 19 59 , and that death occurred at 9:40 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Till Bergemann M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 9314 Jackson St. Hyattsville Md			
PHYSICIAN'S NAME (Type) Dr. Till Bergemann				Maryland			
22. BURIAL, CREMATION, REMOVAL (Specify) 1146-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Mt Carmel		22d. LOCATION (City, town, or county) (State) Upper Marlboro Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Washington				ADDRESS 467 N St NE		24a. REC'D BY REGISTRAR DATE NOV 18 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Fraw			

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12831

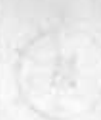
Henry J. Washington
1445 28
1445 28
1445 28

CERTIFICATE OF DEATH

1225

See Dist. No.

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1880</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
6. OCCUPATION <i>Engineer</i>		7. MARITAL STATUS <i>Married</i>		8. COLOR <i>White</i>		9. RELIGION <i>Catholic</i>		10. EDUCATION <i>High School</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. PLACE OF DEATH <i>Home</i>		13. DATE OF DEATH <i>Jan 25 1925</i>		14. TIME OF DEATH <i>10:30 AM</i>		15. SIGNATURE OF DECEASED <i>John J. Smith</i>	
16. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		17. SIGNATURE OF CLERK <i>John D. Smith</i>		18. SIGNATURE OF WITNESS <i>John D. Smith</i>		19. SIGNATURE OF DECEASED <i>John J. Smith</i>		20. SIGNATURE OF DECEASED <i>John J. Smith</i>	
21. SIGNATURE OF DECEASED <i>John J. Smith</i>		22. SIGNATURE OF DECEASED <i>John J. Smith</i>		23. SIGNATURE OF DECEASED <i>John J. Smith</i>		24. SIGNATURE OF DECEASED <i>John J. Smith</i>		25. SIGNATURE OF DECEASED <i>John J. Smith</i>	
26. SIGNATURE OF DECEASED <i>John J. Smith</i>		27. SIGNATURE OF DECEASED <i>John J. Smith</i>		28. SIGNATURE OF DECEASED <i>John J. Smith</i>		29. SIGNATURE OF DECEASED <i>John J. Smith</i>		30. SIGNATURE OF DECEASED <i>John J. Smith</i>	
31. SIGNATURE OF DECEASED <i>John J. Smith</i>		32. SIGNATURE OF DECEASED <i>John J. Smith</i>		33. SIGNATURE OF DECEASED <i>John J. Smith</i>		34. SIGNATURE OF DECEASED <i>John J. Smith</i>		35. SIGNATURE OF DECEASED <i>John J. Smith</i>	
36. SIGNATURE OF DECEASED <i>John J. Smith</i>		37. SIGNATURE OF DECEASED <i>John J. Smith</i>		38. SIGNATURE OF DECEASED <i>John J. Smith</i>		39. SIGNATURE OF DECEASED <i>John J. Smith</i>		40. SIGNATURE OF DECEASED <i>John J. Smith</i>	
41. SIGNATURE OF DECEASED <i>John J. Smith</i>		42. SIGNATURE OF DECEASED <i>John J. Smith</i>		43. SIGNATURE OF DECEASED <i>John J. Smith</i>		44. SIGNATURE OF DECEASED <i>John J. Smith</i>		45. SIGNATURE OF DECEASED <i>John J. Smith</i>	
46. SIGNATURE OF DECEASED <i>John J. Smith</i>		47. SIGNATURE OF DECEASED <i>John J. Smith</i>		48. SIGNATURE OF DECEASED <i>John J. Smith</i>		49. SIGNATURE OF DECEASED <i>John J. Smith</i>		50. SIGNATURE OF DECEASED <i>John J. Smith</i>	
51. SIGNATURE OF DECEASED <i>John J. Smith</i>		52. SIGNATURE OF DECEASED <i>John J. Smith</i>		53. SIGNATURE OF DECEASED <i>John J. Smith</i>		54. SIGNATURE OF DECEASED <i>John J. Smith</i>		55. SIGNATURE OF DECEASED <i>John J. Smith</i>	
56. SIGNATURE OF DECEASED <i>John J. Smith</i>		57. SIGNATURE OF DECEASED <i>John J. Smith</i>		58. SIGNATURE OF DECEASED <i>John J. Smith</i>		59. SIGNATURE OF DECEASED <i>John J. Smith</i>		60. SIGNATURE OF DECEASED <i>John J. Smith</i>	
61. SIGNATURE OF DECEASED <i>John J. Smith</i>		62. SIGNATURE OF DECEASED <i>John J. Smith</i>		63. SIGNATURE OF DECEASED <i>John J. Smith</i>		64. SIGNATURE OF DECEASED <i>John J. Smith</i>		65. SIGNATURE OF DECEASED <i>John J. Smith</i>	
66. SIGNATURE OF DECEASED <i>John J. Smith</i>		67. SIGNATURE OF DECEASED <i>John J. Smith</i>		68. SIGNATURE OF DECEASED <i>John J. Smith</i>		69. SIGNATURE OF DECEASED <i>John J. Smith</i>		70. SIGNATURE OF DECEASED <i>John J. Smith</i>	
71. SIGNATURE OF DECEASED <i>John J. Smith</i>		72. SIGNATURE OF DECEASED <i>John J. Smith</i>		73. SIGNATURE OF DECEASED <i>John J. Smith</i>		74. SIGNATURE OF DECEASED <i>John J. Smith</i>		75. SIGNATURE OF DECEASED <i>John J. Smith</i>	
76. SIGNATURE OF DECEASED <i>John J. Smith</i>		77. SIGNATURE OF DECEASED <i>John J. Smith</i>		78. SIGNATURE OF DECEASED <i>John J. Smith</i>		79. SIGNATURE OF DECEASED <i>John J. Smith</i>		80. SIGNATURE OF DECEASED <i>John J. Smith</i>	
81. SIGNATURE OF DECEASED <i>John J. Smith</i>		82. SIGNATURE OF DECEASED <i>John J. Smith</i>		83. SIGNATURE OF DECEASED <i>John J. Smith</i>		84. SIGNATURE OF DECEASED <i>John J. Smith</i>		85. SIGNATURE OF DECEASED <i>John J. Smith</i>	
86. SIGNATURE OF DECEASED <i>John J. Smith</i>		87. SIGNATURE OF DECEASED <i>John J. Smith</i>		88. SIGNATURE OF DECEASED <i>John J. Smith</i>		89. SIGNATURE OF DECEASED <i>John J. Smith</i>		90. SIGNATURE OF DECEASED <i>John J. Smith</i>	
91. SIGNATURE OF DECEASED <i>John J. Smith</i>		92. SIGNATURE OF DECEASED <i>John J. Smith</i>		93. SIGNATURE OF DECEASED <i>John J. Smith</i>		94. SIGNATURE OF DECEASED <i>John J. Smith</i>		95. SIGNATURE OF DECEASED <i>John J. Smith</i>	
96. SIGNATURE OF DECEASED <i>John J. Smith</i>		97. SIGNATURE OF DECEASED <i>John J. Smith</i>		98. SIGNATURE OF DECEASED <i>John J. Smith</i>		99. SIGNATURE OF DECEASED <i>John J. Smith</i>		100. SIGNATURE OF DECEASED <i>John J. Smith</i>	



THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, HAS THE HONOR TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR THE YEAR 1925.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12873

CERTIFICATE OF DEATH

12855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol Heights</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>36 Capitol Heights</i>	
c. LENGTH OF STAY IN 1b <i>10 years</i>		d. STREET ADDRESS <i>1 807-58th Ave</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>807 58th Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Sophie</i> First <i>M.</i> Middle <i>Cahill</i> Last		4. DATE OF DEATH Month <i>Nov.</i> Day <i>12</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8.8.1890</i>
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Herman Rosenfeld</i>		14. MOTHER'S MAIDEN NAME <i>BERTHA STERIN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>493-24-0582</i>	
17. INFORMANT <i>John G Cahill</i> Address <i>807 58th Ave. Capitol Heights Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>154X</i> DUE TO <i>Generalized Metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Adenocarcinoma of rectum</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>September 1957</i> to <i>11-12-1959</i> , that I last saw the deceased alive on <i>11-12-1959</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Peter Duus</i> M.D.		ADDRESS (Street, city or town, state) <i>6124 Central Ave.</i> DATE SIGNED <i>11-12-59</i>	
PHYSICIAN'S NAME (Type) <i>PETER DUUS</i>		<i>Capitol Heights Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/16/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i> ADDRESS <i>2901 14th St. N.W. Washington, D.C.</i>		24a. REC'D BY REGISTRAR <i>DATE NOV 16 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur & Thoma</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF CHIEF OF POLICE</p>		<p>19. SIGNATURE OF JUDGE</p>		<p>20. SIGNATURE OF SHERIFF</p>	
<p>21. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>22. SIGNATURE OF COUNTY CLERK</p>		<p>23. SIGNATURE OF TOWNSHIP CLERK</p>		<p>24. SIGNATURE OF VILLAGE CLERK</p>	
<p>25. SIGNATURE OF CITY CLERK</p>		<p>26. SIGNATURE OF TOWNSHIP CLERK</p>		<p>27. SIGNATURE OF VILLAGE CLERK</p>		<p>28. SIGNATURE OF CITY CLERK</p>	
<p>29. SIGNATURE OF TOWNSHIP CLERK</p>		<p>30. SIGNATURE OF VILLAGE CLERK</p>		<p>31. SIGNATURE OF CITY CLERK</p>		<p>32. SIGNATURE OF TOWNSHIP CLERK</p>	
<p>33. SIGNATURE OF VILLAGE CLERK</p>		<p>34. SIGNATURE OF CITY CLERK</p>		<p>35. SIGNATURE OF TOWNSHIP CLERK</p>		<p>36. SIGNATURE OF VILLAGE CLERK</p>	
<p>37. SIGNATURE OF CITY CLERK</p>		<p>38. SIGNATURE OF TOWNSHIP CLERK</p>		<p>39. SIGNATURE OF VILLAGE CLERK</p>		<p>40. SIGNATURE OF CITY CLERK</p>	
<p>41. SIGNATURE OF TOWNSHIP CLERK</p>		<p>42. SIGNATURE OF VILLAGE CLERK</p>		<p>43. SIGNATURE OF CITY CLERK</p>		<p>44. SIGNATURE OF TOWNSHIP CLERK</p>	
<p>45. SIGNATURE OF VILLAGE CLERK</p>		<p>46. SIGNATURE OF CITY CLERK</p>		<p>47. SIGNATURE OF TOWNSHIP CLERK</p>		<p>48. SIGNATURE OF VILLAGE CLERK</p>	
<p>49. SIGNATURE OF CITY CLERK</p>		<p>50. SIGNATURE OF TOWNSHIP CLERK</p>		<p>51. SIGNATURE OF VILLAGE CLERK</p>		<p>52. SIGNATURE OF CITY CLERK</p>	
<p>53. SIGNATURE OF TOWNSHIP CLERK</p>		<p>54. SIGNATURE OF VILLAGE CLERK</p>		<p>55. SIGNATURE OF CITY CLERK</p>		<p>56. SIGNATURE OF TOWNSHIP CLERK</p>	
<p>57. SIGNATURE OF VILLAGE CLERK</p>		<p>58. SIGNATURE OF CITY CLERK</p>		<p>59. SIGNATURE OF TOWNSHIP CLERK</p>		<p>60. SIGNATURE OF VILLAGE CLERK</p>	
<p>61. SIGNATURE OF CITY CLERK</p>		<p>62. SIGNATURE OF TOWNSHIP CLERK</p>		<p>63. SIGNATURE OF VILLAGE CLERK</p>		<p>64. SIGNATURE OF CITY CLERK</p>	
<p>65. SIGNATURE OF TOWNSHIP CLERK</p>		<p>66. SIGNATURE OF VILLAGE CLERK</p>		<p>67. SIGNATURE OF CITY CLERK</p>		<p>68. SIGNATURE OF TOWNSHIP CLERK</p>	
<p>69. SIGNATURE OF VILLAGE CLERK</p>		<p>70. SIGNATURE OF CITY CLERK</p>		<p>71. SIGNATURE OF TOWNSHIP CLERK</p>		<p>72. SIGNATURE OF VILLAGE CLERK</p>	
<p>73. SIGNATURE OF CITY CLERK</p>		<p>74. SIGNATURE OF TOWNSHIP CLERK</p>		<p>75. SIGNATURE OF VILLAGE CLERK</p>		<p>76. SIGNATURE OF CITY CLERK</p>	
<p>77. SIGNATURE OF TOWNSHIP CLERK</p>		<p>78. SIGNATURE OF VILLAGE CLERK</p>		<p>79. SIGNATURE OF CITY CLERK</p>		<p>80. SIGNATURE OF TOWNSHIP CLERK</p>	
<p>81. SIGNATURE OF VILLAGE CLERK</p>		<p>82. SIGNATURE OF CITY CLERK</p>		<p>83. SIGNATURE OF TOWNSHIP CLERK</p>		<p>84. SIGNATURE OF VILLAGE CLERK</p>	
<p>85. SIGNATURE OF CITY CLERK</p>		<p>86. SIGNATURE OF TOWNSHIP CLERK</p>		<p>87. SIGNATURE OF VILLAGE CLERK</p>		<p>88. SIGNATURE OF CITY CLERK</p>	
<p>89. SIGNATURE OF TOWNSHIP CLERK</p>		<p>90. SIGNATURE OF VILLAGE CLERK</p>		<p>91. SIGNATURE OF CITY CLERK</p>		<p>92. SIGNATURE OF TOWNSHIP CLERK</p>	
<p>93. SIGNATURE OF VILLAGE CLERK</p>		<p>94. SIGNATURE OF CITY CLERK</p>		<p>95. SIGNATURE OF TOWNSHIP CLERK</p>		<p>96. SIGNATURE OF VILLAGE CLERK</p>	
<p>97. SIGNATURE OF CITY CLERK</p>		<p>98. SIGNATURE OF TOWNSHIP CLERK</p>		<p>99. SIGNATURE OF VILLAGE CLERK</p>		<p>100. SIGNATURE OF CITY CLERK</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12874

CERTIFICATE OF DEATH

12856

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 11426 Cherry Hill Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Christine Middle Violet Last Carroll				4. DATE OF DEATH Month November Day 16 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-11	9. AGE (In years last birthday) yrs. 48	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George W. Carroll				14. MOTHER'S MAIDEN NAME Cora Lee Lipstrap			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-38-3386			
				17. INFORMANT Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia and hemorrhage 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the cervix of uterus DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 7-11 , 19 59 , to 11-16 , 19 59 , that I last saw the deceased alive on 11-16 , 19 59 , and that death occurred at 2:03 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11-16-59							
ACTUAL SIGNATURE Theodore Zegarra, M.D. M.D.							
PHYSICIAN'S NAME (Type) Theodore Zegarra M.D., 4404 Queensbury Rd., Riverdale, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		11/19/59		Fort Lincoln		Colmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home, Inc.				24a. REC'D BY REGISTRAR DATE NOV 20 '59		24b. REGISTRAR'S SIGNATURE	
mt Rainier, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12875

CERTIFICATE OF DEATH

12857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 8 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 4909 Quincy Bladen Street	
3. NAME OF DECEASED (Type or print) First Roy Middle Ernest Last Carter				4. DATE OF DEATH Month Nov Day 18 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 Feb 1909	
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) Yancy County, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Auto Body		11. BIRTHPLACE (State or foreign country) Yancy County, N.C.	
13. FATHER'S NAME Robert Eugene Carter				14. MOTHER'S MAIDEN NAME Clara Blankenship			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Ernest E. Carter, 4909 Quincy St. Bladensburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia with abscess formation DUE TO Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Malnutrition DUE TO (c) Malnutrition							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 49.2 x							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 18, 1959 to Nov 18, 1959 , that I last saw the deceased alive on Nov 18, 1959 , and that death occurred at 5:50 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ronald S. Fleischer				ADDRESS (Street, city or town, state) 5432 Queens Chapel Rd			
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER				DATE SIGNED 11/19/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21/1959		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Asheville, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Chambers, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE NOV 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

W. J. Whelan
Barrington, Illinois

Barack Obama with a copy of the

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12858

12875

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro X			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Carry Mable Chaney				4. DATE OF DEATH Month Day Year November 30, 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1886	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Sears				14. MOTHER'S MAIDEN NAME Ella - ? - Last name unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Louis Henry Chaney, Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd				DATE SIGNED November 30, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/59		22c. NAME OF CEMETERY OR CREMATORY Smithville Cemetery		22d. LOCATION (City, town, or county) (State) Smithville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home- Upper Marlboro, Md.				24a. REC'D BY REGISTRAR DEC 7 59		24b. REGISTRAR'S SIGNATURE Arthur S. Travis	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		TREATMENT _____	
PHYSICIAN'S SIGNATURE _____		MEDICAL EXAMINER'S SIGNATURE _____	
DATE OF EXAMINATION _____		TIME OF EXAMINATION _____	
PLACE OF EXAMINATION _____		NAME OF HOSPITAL _____	
NAME OF PHYSICIAN _____		NAME OF MEDICAL EXAMINER _____	
NAME OF WITNESS _____		NAME OF SECOND WITNESS _____	
NAME OF THIRD WITNESS _____		NAME OF FOURTH WITNESS _____	
NAME OF FIFTH WITNESS _____		NAME OF SIXTH WITNESS _____	
NAME OF SEVENTH WITNESS _____		NAME OF EIGHTH WITNESS _____	
NAME OF NINTH WITNESS _____		NAME OF TENTH WITNESS _____	
NAME OF ELEVENTH WITNESS _____		NAME OF TWELFTH WITNESS _____	
NAME OF THIRTEENTH WITNESS _____		NAME OF FOURTEENTH WITNESS _____	
NAME OF FIFTEENTH WITNESS _____		NAME OF SIXTEENTH WITNESS _____	
NAME OF SEVENTEENTH WITNESS _____		NAME OF EIGHTEENTH WITNESS _____	
NAME OF NINETEENTH WITNESS _____		NAME OF TWENTIETH WITNESS _____	
NAME OF TWENTY-FIRST WITNESS _____		NAME OF TWENTY-SECOND WITNESS _____	
NAME OF TWENTY-THIRD WITNESS _____		NAME OF TWENTY-FOURTH WITNESS _____	
NAME OF TWENTY-FIFTH WITNESS _____		NAME OF TWENTY-SIXTH WITNESS _____	
NAME OF TWENTY-SEVENTH WITNESS _____		NAME OF TWENTY-EIGHTH WITNESS _____	
NAME OF TWENTY-NINTH WITNESS _____		NAME OF THIRTIETH WITNESS _____	
NAME OF THIRTY-FIRST WITNESS _____		NAME OF THIRTY-SECOND WITNESS _____	
NAME OF THIRTY-THIRD WITNESS _____		NAME OF THIRTY-FOURTH WITNESS _____	
NAME OF THIRTY-FIFTH WITNESS _____		NAME OF THIRTY-SIXTH WITNESS _____	
NAME OF THIRTY-SEVENTH WITNESS _____		NAME OF THIRTY-EIGHTH WITNESS _____	
NAME OF THIRTY-NINTH WITNESS _____		NAME OF FORTY WITNESS _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 10a, 10b & 22b, Film G-253 12/8/59.cac. Reg. Dist. No.

13996

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut b. COUNTY Hartford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) T.B.				c. LENGTH OF STAY IN 1b Transient			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dobson's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AARON Middle (N.M.N.) Last COOK				4. DATE OF DEATH Month November Day 11th Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6th, 1909	9. AGE (in years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Security Trader (see below)				10b. KIND OF BUSINESS OR INDUSTRY Brokerage (see below)		11. BIRTHPLACE (State or foreign country) Manchester, Conn.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Garage & gas station operator				14. MOTHER'S MAIDEN NAME Jennie Luce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Elizabeth L. Cook, 562 E. Middle Tpke. Manchester Green, Conn.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive Heart Failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> (Specify) Burial				22b. DATE THEREOF Nov. 18, 1959.		22c. NAME OF CEMETERY East Cemetery	
22d. LOCATION (City, town, or county) (State) Manchester, Connecticut							
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Maryland.				24a. REC'D BY REGISTRAR DATE NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur & Kiana	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. ROY		2. AGE 45		3. SEX Male		4. RACE White	
5. OCCUPATION Carpenter		6. PLACE OF BIRTH Maryland		7. DATE OF BIRTH Nov. 12, 1906		8. PLACE OF DEATH Baltimore, Maryland	
9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural		11. SIGNATURE OF EXAMINER J. J. ROY		12. DATE Nov. 12, 1906	
13. SIGNATURE OF NEXT OF KIN J. J. ROY		14. SIGNATURE OF WITNESSES J. J. ROY		15. SIGNATURE OF CLERK J. J. ROY		16. SIGNATURE OF JURY J. J. ROY	
17. SIGNATURE OF MEDICAL EXAMINER J. J. ROY		18. SIGNATURE OF CLERK J. J. ROY		19. SIGNATURE OF JURY J. J. ROY		20. SIGNATURE OF WITNESSES J. J. ROY	
21. SIGNATURE OF NEXT OF KIN J. J. ROY		22. SIGNATURE OF WITNESSES J. J. ROY		23. SIGNATURE OF CLERK J. J. ROY		24. SIGNATURE OF JURY J. J. ROY	
25. SIGNATURE OF MEDICAL EXAMINER J. J. ROY		26. SIGNATURE OF CLERK J. J. ROY		27. SIGNATURE OF JURY J. J. ROY		28. SIGNATURE OF WITNESSES J. J. ROY	
29. SIGNATURE OF NEXT OF KIN J. J. ROY		30. SIGNATURE OF WITNESSES J. J. ROY		31. SIGNATURE OF CLERK J. J. ROY		32. SIGNATURE OF JURY J. J. ROY	
33. SIGNATURE OF MEDICAL EXAMINER J. J. ROY		34. SIGNATURE OF CLERK J. J. ROY		35. SIGNATURE OF JURY J. J. ROY		36. SIGNATURE OF WITNESSES J. J. ROY	
37. SIGNATURE OF NEXT OF KIN J. J. ROY		38. SIGNATURE OF WITNESSES J. J. ROY		39. SIGNATURE OF CLERK J. J. ROY		40. SIGNATURE OF JURY J. J. ROY	
41. SIGNATURE OF MEDICAL EXAMINER J. J. ROY		42. SIGNATURE OF CLERK J. J. ROY		43. SIGNATURE OF JURY J. J. ROY		44. SIGNATURE OF WITNESSES J. J. ROY	
45. SIGNATURE OF NEXT OF KIN J. J. ROY		46. SIGNATURE OF WITNESSES J. J. ROY		47. SIGNATURE OF CLERK J. J. ROY		48. SIGNATURE OF JURY J. J. ROY	
49. SIGNATURE OF MEDICAL EXAMINER J. J. ROY		50. SIGNATURE OF CLERK J. J. ROY		51. SIGNATURE OF JURY J. J. ROY		52. SIGNATURE OF WITNESSES J. J. ROY	
53. SIGNATURE OF NEXT OF KIN J. J. ROY		54. SIGNATURE OF WITNESSES J. J. ROY		55. SIGNATURE OF CLERK J. J. ROY		56. SIGNATURE OF JURY J. J. ROY	
57. SIGNATURE OF MEDICAL EXAMINER J. J. ROY		58. SIGNATURE OF CLERK J. J. ROY		59. SIGNATURE OF JURY J. J. ROY		60. SIGNATURE OF WITNESSES J. J. ROY	
61. SIGNATURE OF NEXT OF KIN J. J. ROY		62. SIGNATURE OF WITNESSES J. J. ROY		63. SIGNATURE OF CLERK J. J. ROY		64. SIGNATURE OF JURY J. J. ROY	
65. SIGNATURE OF MEDICAL EXAMINER J. J. ROY		66. SIGNATURE OF CLERK J. J. ROY		67. SIGNATURE OF JURY J. J. ROY		68. SIGNATURE OF WITNESSES J. J. ROY	
69. SIGNATURE OF NEXT OF KIN J. J. ROY		70. SIGNATURE OF WITNESSES J. J. ROY		71. SIGNATURE OF CLERK J. J. ROY		72. SIGNATURE OF JURY J. J. ROY	
73. SIGNATURE OF MEDICAL EXAMINER J. J. ROY		74. SIGNATURE OF CLERK J. J. ROY		75. SIGNATURE OF JURY J. J. ROY		76. SIGNATURE OF WITNESSES J. J. ROY	
77. SIGNATURE OF NEXT OF KIN J. J. ROY		78. SIGNATURE OF WITNESSES J. J. ROY		79. SIGNATURE OF CLERK J. J. ROY		80. SIGNATURE OF JURY J. J. ROY	
81. SIGNATURE OF MEDICAL EXAMINER J. J. ROY		82. SIGNATURE OF CLERK J. J. ROY		83. SIGNATURE OF JURY J. J. ROY		84. SIGNATURE OF WITNESSES J. J. ROY	
85. SIGNATURE OF NEXT OF KIN J. J. ROY		86. SIGNATURE OF WITNESSES J. J. ROY		87. SIGNATURE OF CLERK J. J. ROY		88. SIGNATURE OF JURY J. J. ROY	
89. SIGNATURE OF MEDICAL EXAMINER J. J. ROY		90. SIGNATURE OF CLERK J. J. ROY		91. SIGNATURE OF JURY J. J. ROY		92. SIGNATURE OF WITNESSES J. J. ROY	
93. SIGNATURE OF NEXT OF KIN J. J. ROY		94. SIGNATURE OF WITNESSES J. J. ROY		95. SIGNATURE OF CLERK J. J. ROY		96. SIGNATURE OF JURY J. J. ROY	
97. SIGNATURE OF MEDICAL EXAMINER J. J. ROY		98. SIGNATURE OF CLERK J. J. ROY		99. SIGNATURE OF JURY J. J. ROY		100. SIGNATURE OF WITNESSES J. J. ROY	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12877

CERTIFICATE OF DEATH

Reg. Dist. No.

12859

1. PLACE OF DEATH a. COUNTY <u>Pr. George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>3704 Taylor St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>P.</u> Last <u>Cusick</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 19, 1888</u> 71 yrs.	
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H-wife</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Reamy</u>				14. MOTHER'S MAIDEN NAME <u>Maggie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John R. Cusick, Jr.</u>		Address <u>Same as #2.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 15, 1957</u> to <u>Nov 27, 1959</u> , that I last saw the deceased alive on <u>Nov. 26, 1959</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>3701 Leland St, Chevy Chase, Md. 11-27-59</u>							
ACTUAL SIGNATURE <u>J. Raymond Raedy</u>				M.D. <u>3701 Leland St, Chevy Chase, Md. 11-27-59</u>			
PHYSICIAN'S NAME (Type) <u>J. Raymond Raedy</u>				ADDRESS <u>3701 Leland St, Chevy Chase, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-30-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>				ADDRESS <u>5801 Cleveland Ave Riverdale, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1, '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Christina S. Hunt</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[The page contains faint, illegible text, likely bleed-through from the reverse side.]

CERTIFICATE OF DEATH

12860

Reg. Dist. No.

12927

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stella Juliette Danenhower		4. DATE OF DEATH Nov 22 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Home-Farm	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Edward B. Danenhower, Jr.-Maryland;		Address Upper Marlboro	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Disease DUE TO (c) 2300		INTERVAL BETWEEN ONSET AND DEATH 2300	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 Nov 1959 , to Nov 22 1959 , that I last saw the deceased alive on Nov 26 1959 , and that death occurred at 10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R B Sasscer		DATE SIGNED Upper Marlboro, Md Nov 27 1959	
PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.		Address Upper Marlboro, Maryland;	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/59	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.		ADDRESS Upper	
24a. REC'D BY REGISTRAR DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

12861

1. PLACE OF DEATH a. COUNTY <i>Prince George's Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Pr. Geo. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Landover Hills, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Landover Hills</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>4402 62nd Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Isabel</i> Middle <i>Lewis</i> Last <i>Davis</i>		4. DATE OF DEATH Month <i>November</i> Day <i>6</i> Year <i>1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/22/1883</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months <i>76</i> Days <i>76</i> Hours <i>76</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Walker Lewis</i>		14. MOTHER'S MAIDEN NAME <i>Jane Page</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Archie Marchis D. Davis</i>		Address <i>Hills, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lymphosarcoma</i> <i>200.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>January, 1958</i> to <i>Nov 6, 1959</i> , that I last saw the deceased alive on <i>11/6/59</i> , and that death occurred at <i>8:45 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F.E. Musser</i>		ADDRESS (Street, city or town, state) <i>4410 74th Ave</i> DATE SIGNED <i>11/6/59</i>	
PHYSICIAN'S NAME (Type) <i>F.E. Musser</i>		<i>Bellemeade, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>	22b. DATE THEREOF <i>11/10/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Crematory</i>	22d. LOCATION (City, town, or county) (State) <i>Pr. Geo. Co., Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co., 2901 14th St. N.W.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 9 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

CERTIFICATE OF DEATH

1932

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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12878

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12862

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 of this Medical Examiner's Certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 East Riverdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 6319 Longfellow Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First David Middle Robert Last Dennis			4. DATE OF DEATH Month November Day 6 Year 19 59		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-41		9. AGE (In years last birthday) 18 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock clerk		10b. KIND OF BUSINESS OR INDUSTRY Department store		11. BIRTHPLACE (State or foreign country) Dist. of Columbia	
13. FATHER'S NAME Charles Joseph Dennis			14. MOTHER'S MAIDEN NAME Maudie F. Reh		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Charles Joseph Dennis; same address as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture dislocation of cervical vertebra 822X TO and fractured skull and compression of chest. Conditions, if any, which gave rise to immediate cause (b) Automobile accident (c) Due to DUE TO (c) Automobile accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Automobile accident					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile that turned over.			
20c. TIME OF INJURY Month, Day, Year 10:55 p.m. 11-6-59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
				20f. (City or town) (County) (State) Berwyn Heights- Pr. Geo. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				November 9, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF nov 11, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Washington National	
				22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			24a. REC'D BY REGISTRAR DATE NOV 12 '59		
			24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

12812

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. JONES		SEX Male		AGE 35	
DATE OF DEATH November 10, 1932		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		LOCALITY Baltimore, Md.	
SIGNS AND SYMPTOMS Sudden death, no previous illness.		POST-MORTEM EXAMINATION No autopsy performed.		FINDINGS Coronary artery disease.	
CERTIFICATE OF DEATH This is to certify that the above named person died on the 10th day of November, 1932, at the age of 35 years, from the cause stated above.		SIGNATURE OF EXAMINER J. H. Jones		DATE November 10, 1932	
LOCALITY Baltimore, Md.		COUNTY Baltimore		STATE Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12863

Reg. Dist. No.

12929

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxen Hill			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George County Jail				d. STREET ADDRESS 6149 Charles Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELMER Middle CECIL Last DUCKETT				4. DATE OF DEATH Month November 14, Day 1959 Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> Married	8. DATE OF BIRTH April 13, 1905		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY St. Elizabeth Hosp. Hartford, Tenn.		11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel P. Duckett				14. MOTHER'S MAIDEN NAME Mattie Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address 6149 Charles Way, Mr. Herbert G. Clark, Oxen Hill, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock <div style="margin-left: 20px;">981X DUE TO</div> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="margin-left: 20px;">(b) Gun Shot wound in Chest <div style="margin-left: 20px;">(c)</div> </div></p> </p></div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> </div> <div style="width: 70%;"> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot while resisting Arrest.</p> </div> </div>							
20c. TIME OF INJURY Month, Day, Year Hour 9:40 P. M. 11/ 14/ 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jail		20f. (City or town) (County) (State) Upper Marlboro, P.G.Cty., Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 15, 1959.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros</i>				24a. REC'D BY REGISTRAR Wash., D.C. NOV 18 '59		24b. REGISTRAR'S SIGNATURE <i>William S. Kraus</i>	
SIMMONS BROS. FUNERAL HOME, 1661 Good Hope Rd., SE							

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Doe	
Sex		Male	
Age		45	
Date of Birth		January 15, 1905	
Place of Birth		Baltimore, Md.	
Usual Residence		123 Main St., Baltimore, Md.	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Date of Death		November 10, 1955	
Time of Death		10:00 AM	
Place of Death		Home	
Signature of Coroner		[Signature]	
Date of Certificate		November 15, 1955	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12864

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY 12930 Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In front of Fire House		e. STREET ADDRESS Tracey's Landing 02X-2	
3. NAME OF DECEASED (Type or print) EVERETT First NICHOLAS Middle EASTON Last		4. DATE OF DEATH Month November Day 5th Year 19 59	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5th, 1925	
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 5 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer--Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Chaneyville, Calvert Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Henry Easton		14. MOTHER'S MAIDEN NAME Helen Mamie Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Richard H. Easton, Tracey's Landing, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage & shock 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gumshot wounds of chest and abdomen DUE TO (c) </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation	
20c. TIME OF INJURY Month, Day, Year 9:00 Hour 11/5/ 19 59 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Croome, Pr. Geo. Co., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/6/1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-5-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Coopers		22d. LOCATION (City, town, or county) (State) Dunkirk, Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell</i>		24a. REC'D BY REGISTRAR NOV 17 '59	
ADDRESS <i>Prince Frederick, Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Lewis</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1930

Place George

John Wilson

Age of Deceased

Married

Single

Married - Half-blood

Richard Henry Wilson

Place

Married - Half-blood

Married - Half-blood

Married - Half-blood

Married - Half-blood

Married - Half-blood

Married - Half-blood

Married - Half-blood

Married - Half-blood

Married - Half-blood

Married - Half-blood

Married - Half-blood

Married - Half-blood

John Wilson

Age of Deceased

Married

Single

Married - Half-blood

Richard Henry Wilson

Place

Married - Half-blood

Married - Half-blood

Married - Half-blood

Married - Half-blood

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Married - Half-blood

Married - Half-blood

Place George

John Wilson

Age of Deceased

Married

Single

Married - Half-blood

Richard Henry Wilson

Place

Married - Half-blood

Married - Half-blood

Married - Half-blood

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Married - Half-blood

Married - Half-blood

Place George

John Wilson

Age of Deceased

Married

Single

Married - Half-blood

Richard Henry Wilson

Place

Married - Half-blood

Married - Half-blood

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12865

12879

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Prince George b. COUNTY State, Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 27 Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS 5208 Nye St. N.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lucy Middle Mary Last Fields				4. DATE OF DEATH Month Nov. Day 2 Year 1959			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25, 1906	
9. AGE (In years lost birthday) yrs. 52		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Leonardtwn, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Henry Hayden				14. MOTHER'S MAIDEN NAME Sophie Holley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. 			
INFORMANT Mr. Roland Fields				Address 5208 Nye St., N. E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio vascular renal disease DUE TO (c) 							
INTERVAL BETWEEN ONSET AND DEATH 10 days yes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 14 , 19 59 to Nov. 2 , 19 59 , that I last saw the deceased alive on Nov. 2 , 19 59 , and that death occurred at 6:57 P M, from the causes and on the date stated above. ACTUAL SIGNATURE Tia Bergeron ADDRESS (Street, city or town, state) 4314 Jettah St. Hyattsville DATE SIGNED Nov. 2 PHYSICIAN'S NAME (Type) Mary Land							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. R. Hunter Washington D.C.				24a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

2

077

1

12321

222-30-1282

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12866**

12931

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Dist. of Col. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6622 23rd Avenue				d. STREET ADDRESS 2517 Mozart Place			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First William Middle Francis Last Fitzgerald		4. DATE OF DEATH		Month November Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-06		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Jus.		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Fitzgerald				14. MOTHER'S MAIDEN NAME Mary A. McGrath			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-54-5906		17. INFORMANT Address Douglas A. Clark; Warner Bldg. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary and cerebral edema 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute congestive heart failure DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		November 23, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/59		22c. NAME OF CEMETERY OR CREMATORY St John's Cemetery		22d. LOCATION (City, town, or county) (State) Norwalk Connecticut	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 25 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE IN BOX		DATE OF DEATH	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. RACE	
5. OCCUPATION		6. PLACE OF BIRTH	
7. MARITAL STATUS		8. DATE OF MARRIAGE	
9. NAME OF SPOUSE		10. NAME OF CHILDREN	
11. NAME OF NEXT OF KIN		12. NAME OF PHYSICIAN	
13. NAME OF HOSPITAL		14. NAME OF NURSING HOME	
15. NAME OF HOME		16. NAME OF PLACE	
17. NAME OF STREET		18. NAME OF CITY	
19. NAME OF STATE		20. NAME OF COUNTRY	
21. NAME OF COUNTY		22. NAME OF TOWN	
23. NAME OF VILLAGE		24. NAME OF POST OFFICE	
25. NAME OF ZIP CODE		26. NAME OF PHONE NUMBER	
27. NAME OF TELEPHONE NUMBER		28. NAME OF TELETYPE NUMBER	
29. NAME OF TELEFAX NUMBER		30. NAME OF TELEVISION NUMBER	
31. NAME OF RADIO NUMBER		32. NAME OF CABLE NUMBER	
33. NAME OF FAX NUMBER		34. NAME OF INTERNET NUMBER	
35. NAME OF E-MAIL NUMBER		36. NAME OF MOBILE NUMBER	
37. NAME OF LANDLINE NUMBER		38. NAME OF VOIP NUMBER	
39. NAME OF OTHER NUMBER		40. NAME OF OTHER NUMBER	
41. NAME OF OTHER NUMBER		42. NAME OF OTHER NUMBER	
43. NAME OF OTHER NUMBER		44. NAME OF OTHER NUMBER	
45. NAME OF OTHER NUMBER		46. NAME OF OTHER NUMBER	
47. NAME OF OTHER NUMBER		48. NAME OF OTHER NUMBER	
49. NAME OF OTHER NUMBER		50. NAME OF OTHER NUMBER	
51. NAME OF OTHER NUMBER		52. NAME OF OTHER NUMBER	
53. NAME OF OTHER NUMBER		54. NAME OF OTHER NUMBER	
55. NAME OF OTHER NUMBER		56. NAME OF OTHER NUMBER	
57. NAME OF OTHER NUMBER		58. NAME OF OTHER NUMBER	
59. NAME OF OTHER NUMBER		60. NAME OF OTHER NUMBER	
61. NAME OF OTHER NUMBER		62. NAME OF OTHER NUMBER	
63. NAME OF OTHER NUMBER		64. NAME OF OTHER NUMBER	
65. NAME OF OTHER NUMBER		66. NAME OF OTHER NUMBER	
67. NAME OF OTHER NUMBER		68. NAME OF OTHER NUMBER	
69. NAME OF OTHER NUMBER		70. NAME OF OTHER NUMBER	
71. NAME OF OTHER NUMBER		72. NAME OF OTHER NUMBER	
73. NAME OF OTHER NUMBER		74. NAME OF OTHER NUMBER	
75. NAME OF OTHER NUMBER		76. NAME OF OTHER NUMBER	
77. NAME OF OTHER NUMBER		78. NAME OF OTHER NUMBER	
79. NAME OF OTHER NUMBER		80. NAME OF OTHER NUMBER	
81. NAME OF OTHER NUMBER		82. NAME OF OTHER NUMBER	
83. NAME OF OTHER NUMBER		84. NAME OF OTHER NUMBER	
85. NAME OF OTHER NUMBER		86. NAME OF OTHER NUMBER	
87. NAME OF OTHER NUMBER		88. NAME OF OTHER NUMBER	
89. NAME OF OTHER NUMBER		90. NAME OF OTHER NUMBER	
91. NAME OF OTHER NUMBER		92. NAME OF OTHER NUMBER	
93. NAME OF OTHER NUMBER		94. NAME OF OTHER NUMBER	
95. NAME OF OTHER NUMBER		96. NAME OF OTHER NUMBER	
97. NAME OF OTHER NUMBER		98. NAME OF OTHER NUMBER	
99. NAME OF OTHER NUMBER		100. NAME OF OTHER NUMBER	

CERTIFICATE OF DEATH

Reg. Dist. No.

12867

12932

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>15</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>FRIEDSON</u> Last <u>FRIEDSON</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25 1893</u>	9. AGE (In years lost birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUG</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Elhanon Friedson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Diamondson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>MATTH FRANK -4311-H ST SE. Wash. D.C.</u>		INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>several years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>51</u> , to <u>Nov 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 14</u> , 19 <u>59</u> , and that death occurred <u>Nov 25</u> , 19 <u>59</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irwin I. Xager</u>		ADDRESS (Street, city or town, state) <u>3055-16 St. N. W. Nov 25 1959 WASHINGTON, D.C.</u>					
PHYSICIAN'S NAME (Type) <u>IRWIN I. XAGER</u>		DATE SIGNED <u>NOV 30 '59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem Garden</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Sons</u>		ADDRESS <u>3501-14th St N.W.</u>		24a. REC'D BY REGISTRAR <u>NOV 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1887

CERTIFICATE OF DEATH

1893



12933

CERTIFICATE OF DEATH

Reg. Dist. No.

12868

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN lb 14 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ADLAI Middle H Last GILKESON				4. DATE OF DEATH Month NOVEMBER Day 2 Year 19 59			
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 JAN 1893	
9. AGE (In years lost birthday) yrs. 66		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF				10b. KIND OF BUSINESS OR INDUSTRY RETIRED USAF		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME ANDREW GILKESON				14. MOTHER'S MAIDEN NAME JANE MCNEIL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES 1911 TO 1953				16. SOCIAL SECURITY NO. 231-52-7278		INFORMANT WIFE	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL PULMONARY EDEMA AND ATELECTASIS AND IN- 163X DUE TO FRACTION RIGHT LOWER LOBE LUNG RESECTION FOR CANCER Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) RIGHT LOWER LOBE LUNG RESECTION FOR CANCER (c) RIGHT LOWER LOBE LUNG RESECTION FOR CANCER				INTERVAL BETWEEN ONSET AND DEATH 48 HOURS 72 HOURS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CANCER OF LUNG: PREVIOUS HEART ATTACK: METASTATIC CARCINOMA				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 19 OCTOBER , 1959, to 2 NOVEMBER , 1959, that I last saw the deceased alive on 2 NOVEMBER , 1959, and that death occurred at 3:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS DATE SIGNED 2 NOV 59							
ACTUAL SIGNATURE Phillip A. Cox M.D. USAF HOSPITAL ANDREWS				DATE SIGNED 2 NOV 59			
PHYSICIAN'S NAME (Type) PHILLIP A COX LT COL USAF MC				USAF HOSPITAL ANDREWS, ANDREWS AFB, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 5, 1959		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Michael Funeral Home				ADDRESS 816 H St. NE. Wash DC		24a. REC'D BY REGISTRAR NOV 5 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

CERTIFICATE OF DEATH

1993

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

NAME: _____

DATE: _____

LOCATION: _____

CAUSE OF DEATH: _____

SIGNATURE: _____

12860

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Takoma</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1211 Elson Place</u>		d. STREET ADDRESS <u>1211 Elson Place</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>STEVEN</u> Middle <u>REICH</u> Last <u>GILL</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27, 1959</u>
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>22</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles R. Gill</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Stuntz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>M. Charles R. Gill, 1211 Elson Pl. T.P. Md.</u>		Address <u>1211 Elson Pl. T.P. Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congenital heart disease</u> <u>754.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Truncus arteriosus</u> DUE TO (c) <u>+ IV septal defect</u>		INTERVAL BETWEEN ONSET AND DEATH <u>life</u> <u>life</u> <u>life</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>29 Sept</u> , 1959, to <u>11/19</u> , 1959, that I last saw the deceased alive on <u>11/17/59</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Joseph J. McDonald M.D.</u>	DATE SIGNED <u>7309 Riggs Rd, W. Hyattsville Md.</u>
PHYSICIAN'S NAME (Type) <u>JOSEPH J. McDONALD M.D.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 20, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll Dr NW DC.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G252 11-23-59 et

CERTIFICATE OF DEATH

12870

Reg. Dist. No.

12880

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>56 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Mt. Rainier</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>3815 37th St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>T.</u> Last <u>Gilmore</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 Oct. 1892</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u> Hours <u>15</u> Min.	IF UNDER 24 HRS. Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Photographer</u>		11. BIRTHPLACE (State or foreign country) <u>Piedmont, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Louise - ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>not</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-10-1656</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>518x</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Empyema</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombosis of portal vein with embolus of liver</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 9</u> , 19 <u>59</u> , to <u>Nov. 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 14</u> , 19 <u>59</u> , and that death occurred at <u>3:55 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>K. Wolf</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>11/14/59</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD S. FLEISCHER</u>				<u>11/14/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) <u>Colmar Manor, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u> ADDRESS <u>Mt. Rainier, Md.</u>				24. REC'D BY REGISTRAR DATE <u>NOV 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kinner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1881

1880

CERTIFICATE OF DEATH

1880

1

[Faint, mostly illegible text from a form, likely a death certificate. The text is mirrored across the page, suggesting bleed-through from the reverse side. Discernible words include "CERTIFICATE OF DEATH", "1880", and "1881".]

12881

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Earl Middle Goodwin Last				4. DATE OF DEATH Month Nov Day 15 Year 1959			
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 July 1912	9. AGE (In years lost birthday) yrs. 47	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jerry Goodwin				14. MOTHER'S MAIDEN NAME Della Bradshaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		INFORMANT Wife, Constance		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Multiple brain hemorrhages (b) Hypertensive cardiovascular and renal disease. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 hours						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 14, 1959 to Nov. 15, 1959, that I last saw the deceased alive on Nov. 14, 1959, and that death occurred at 3:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. and Fleischer		ADDRESS (Street, city or town, state) 5432 Queen Annapolis Rd DATE SIGNED 11/14/59					
PHYSICIAN'S NAME (Type) RONALD S FLEISCHER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-59		22c. NAME OF CEMETERY OR CREMATORY Union Bethel Church Cemetery		22d. LOCATION (City, town, or county) (State) J.B. Prince Georges, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE MURPHY J. ROBINSON				ADDRESS 909-6 52 h w		24a. REC'D BY REGISTRAR DATE NOV 20 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knapp			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1541

12321



12934

CERTIFICATE OF DEATH

Reg. Dist. No.

12872

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 319 OTTAWA ST b. COUNTY FOREST HES. M.D.P.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL, Andrews				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle E Last GREEN				4. DATE OF DEATH Month November Day 23 Year 1959			
5. SEX Female		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 JUNE 1872	
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 87 Days 87 Hours 87 Min.		11. BIRTHPLACE (State or foreign country) MASCOUTAH, ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY —			
13. FATHER'S NAME Joseph LINN				14. MOTHER'S MAIDEN NAME EMMA LINN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNK		INFORMANT INEZ N. ROUSOM (D) Address 319 OTTAWA ST FOREST HES, WASH 24, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema & pleural effusion 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure & calcified mitral ring DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 1 hour 30 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 23 , 19 59 , to Nov 23 , 19 59 , that I last saw the deceased alive on 1900 , 19 59 and that death occurred at 1940 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Murray Shevick		ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS				DATE SIGNED 23 Nov 59	
PHYSICIAN'S NAME (Type) MURRAY SHEVICK, CAPT, USAF, MC		USAF HOSPITAL ANDREWS, ANDREWS AFB, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 25 1959		22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON DC.	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home 816 H St. N.E. WASH 20C.				24a. REC'D BY REGISTRAR DATE NOV 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1999

CERTIFICATE OF DEATH

1999

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Signature of informant: _____

11. Name of informant: _____

12. Address of informant: _____

13. Date of completion: _____

14. Registrar's stamp: _____

15. Medical examiner's stamp: _____

16. Coroner's stamp: _____

17. Burial place: _____

18. Burial date: _____

19. Burial time: _____

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200. Burial place: _____

12882

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wash., 23		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 54 Swann Rd., S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick Middle C Last Gromen				4. DATE OF DEATH Month Nov. Day 19 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-30-24	
9. AGE (In years lost birthday) 35 yrs.		10. IF UNDER 1 YEAR Months 35 Days 35 Hours 35 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry and Dry Cleaning				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Michael Gromen				14. MOTHER'S MAIDEN NAME Lena Irre			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WWII 212-20-0850		INFORMANT Michael Gromen Address 54 Swann Rd., S.E. Suitland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190.9 Malignant Melanoma DUE TO (b) 5 yrs Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) 5 yrs							INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema. (b) Carcinomatosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 55 , to Nov 19 , 19 59 , that I last saw the deceased alive on Nov 19 , 19 59 , and that death occurred at 9:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald W. Mitchell				ADDRESS (Street, city or town, state) 1746 K St NW Washington, D.C.			
PHYSICIAN'S NAME (Type) Dr. Donald W. Mitchell				DATE SIGNED Nov 23 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Pr. Geo. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Summers Bros 1661 Grosvenor Rd.				24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

100-10

CERTIFICATE OF BIRTH

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12935

CERTIFICATE OF DEATH

12874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN 1b 3 HRS 20 MINS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOTHIAN 02X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS CRANDELL ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First MANUEL Middle J Last GROPPER		4. DATE OF DEATH		Month NOVEMBER Day 1 Year 19 59	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 DEC 1895		9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		10b. KIND OF BUSINESS OR INDUSTRY SMITHONIAN INSTITUTE		11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES 1920 TO 1946		16. SOCIAL SECURITY NO. 217-28-8573		INFORMANT DAUGHTER DEBORAH E CLEMENTS		Address 417 50TH AVENUE CAPITOL HEIGHTS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 NOVEMBER , 19 59 , to 1 NOVEMBER , 19 59 , that I last saw the deceased alive on 1 NOVEMBER , 19 59 , and that death occurred at 11:10A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF HOSPITAL ANDREWS 1 NOV 59							
ACTUAL SIGNATURE <i>Reginald P McManus</i>		M.D. USAF HOSPITAL ANDREWS 1 NOV 59					
PHYSICIAN'S NAME (Type) REGINALD P MCMANUS CAPT USAF MC USAF HOSPITAL ANDREWS, ANDREWS AFB, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-59		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co. Inc. Washington, D.C.				24a. REC'D BY REGISTRAR NOV 4 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur G. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1887

CERTIFICATE OF DEATH

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MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

may be relied upon by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12883

CERTIFICATE OF DEATH

12875

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park d. STREET ADDRESS 4000 College Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elsie Middle C Last Hammersmith				4. DATE OF DEATH Month Nov Day 19 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14 1900	
9. AGE (In years lost birthday) yrs. 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME John Keller				14. MOTHER'S MAIDEN NAME Anna Kochis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Mrs H J Isabell		Address University Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 cardiac arrest DUE TO (b) atherosclerotic heart disease DUE TO (c) lying cause lost. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 3 min 14
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ca of pneumonia & liver metastases							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1st, 1959 , to Nov. 19th, 1959 , that I last saw the deceased alive on Nov 19 , 19 59 , and that death occurred at 1:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Til Bergman				ADDRESS (Street, city or town, state) 4314 College Park St			
PHYSICIAN'S NAME (Type) Dr. Til Bergman, M.D.				DATE SIGNED Hyattsville Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/23/59		22c. NAME OF CEMETERY OR CREMATORY St Peter & Paul Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

12883

Deceased Person

Place of Birth

Infant's Sex

Age

Gender

Place of Death

Date of Death

Time of Death

Hour

Minute

Place of Death

Place of Death

Signature of Physician

Signature of Physician

Date

Blank area for additional information and signatures.

CERTIFICATE OF DEATH

Reg. Dist. No.

12884

12876

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Harber Last Harber		4. DATE OF DEATH Month Nov Day 17 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 July 1880
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry J. Hartman		14. MOTHER'S MAIDEN NAME Hudie Graulich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Mt. Rainier	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 260x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 3 days years 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 14, 1959 to Nov 17, 1959 , that I last saw the deceased alive on Nov 16, 1959 , and that death occurred at 1:50 A. from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin S. Miller M.D.		ADDRESS (Street, city or town, state) 3824-34th Mt Rainier DATE SIGNED 11/17/59	
PHYSICIAN'S NAME (Type) BENJAMIN S. MILLER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Long Island, New York	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons-3501 14th Street, N.W.		24a. REC'D BY REGISTRAR NOV 19 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1988

1. Name of deceased: *John Doe*
2. Date of death: *10/15/88*
3. Place of death: *Home*
4. Cause of death: *Heart Disease*
5. Age at death: *75*
6. Sex: *Male*
7. Race: *White*
8. Marital status: *Married*
9. Occupation: *Teacher*
10. Signature of physician: *[Signature]*
11. Signature of registrar: *[Signature]*
12. Date of registration: *10/20/88*
13. Place of registration: *New York City*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12936

CERTIFICATE OF DEATH

12877

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Hgts</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>912-64th Ave. Cedar Hgts</u>				d. STREET ADDRESS <u>1912-64th Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wilbur Benjamin Harris</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1893</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscaper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>S. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>225-30 988</u>		17. INFORMANT <u>Madeline Harris - 912-64th Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchial Asthma</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-5-</u> , 1959, to <u>11-6-</u> , 1959, that I last saw the deceased alive on <u>11-6-</u> , 1959, and that death occurred at <u>3:50 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Robinson</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1801 Eastern Ave. N.E. 11-6-59</u>			
PHYSICIAN'S NAME (Type) <u>John W. Robinson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-10-59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Ch. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Powhatan Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u> ADDRESS <u>467 N. St. W.W.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12885

CERTIFICATE OF DEATH

Reg. Dist. No.

12878

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 5 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 6903 Dartmouth Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FLORENCE Middle ANNISE Last HARRISON				4. DATE OF DEATH Month November Day 2nd , Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 19th, 1889		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Brandon, Vermont		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George M. Norton				14. MOTHER'S MAIDEN NAME Jennie L. Murray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-01-4832B		17. INFORMANT James W. Harrison, 6903 Dartmouth Ave., Address College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease (c) 12 hrs 5 yrs 6 yrs							INTERVAL BETWEEN ONSET AND DEATH 12 hrs 5 yrs 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from Jan , 19 53 to Nov , 19 59 , that I last saw the deceased alive on Nov 2 , 19 59 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3824-34th Tr. Rd. Baltimore DATE SIGNED 11-2-59 ACTUAL SIGNATURE Benjamin S. Miller M.D. PHYSICIAN'S NAME (Type) Benjamin S. Miller							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 5th, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE NOV 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12886

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>11 Hr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>15731 29th Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>L</u> Last <u>Hathaway</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9, 1906</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager of Bakery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Safeway Stores</u>	
11. BIRTHPLACE (State or foreign country) <u>Bennington, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dana Hathaway</u>		14. MOTHER'S MAIDEN NAME <u>Zura Agnes Startzman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>511-07-9915</u>	
17. INFORMANT <u>Paul L. Hathaway Jr.</u>		Address <u>1030-Nolan Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-1</u> , 19 <u>59</u> , to <u>11-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-2</u> , 19 <u>59</u> , and that death occurred at <u>10:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Fleischer</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>11/2/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Fleischer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-5-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley Funeral Home</u>		ADDRESS <u>mt. Rainier Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knud</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12886

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Lanhorn Hills		c. LENGTH OF STAY IN 1b 4 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X W. Lanhorn			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7730 - Garrison				d. STREET ADDRESS 1 7730 - Garrison		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bonnie C. Hawkins				4. DATE OF DEATH 11-7-59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-59		9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy J. Hawkins				14. MOTHER'S MAIDEN NAME Martha White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Roy J. Hawkins, same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) DUE TO cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JOHN T. MALONEY M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11-7-59.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 10, 1959		22c. NAME OF CEMETERY OR OTHER PLACE OF INTERMENT Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Maryland.		24a. REC'D BY REGISTRAR DATE NOV 10 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf d. STREET ADDRESS Rt.1 Box 59		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mildred Middle Last Hawkins		4. DATE OF DEATH Month Nov. Day 17 Year 19 59			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-13	9. AGE (In years last birthday) 46 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Harper			
14. MOTHER'S MAIDEN NAME Harriett Miller		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. INFORMANT Harriett Harper, Waldorf, Maryland		17. ADDRESS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) subarachnoid hemorrhage DUE TO 452x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aneurysm Circle of Willis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 days UNKNOWN					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nov 5, 1959, to Nov 17, 1959	
20f. (City or town) Nov 5, 1959		20g. (County) Nov 17, 1959		20h. (State) Nov 17, 1959	
21. I certify that I attended the deceased from Nov 5, 1959 to Nov 17, 1959 that I last saw the deceased alive on Nov. 17, 19 59 and that death occurred at 8:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3503 Perry St. Md. DATE SIGNED 11/17/59 ACTUAL SIGNATURE Norman D. Comeau M.D. PHYSICIAN'S NAME (Type) Dr. Comeau (Norman) MT Rainier Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-59		22c. NAME OF CEMETERY OR CREMATORY St Peters	
22d. LOCATION (City, town, or county) Waldorf, Maryland		22e. (State) Waldorf, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR NOV 23 '59		24b. REGISTRAR'S SIGNATURE Charles L. Howard	

1237

STATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12882

12888

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roadside md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park 14</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>		d. STREET ADDRESS <u>8703 49th AVE</u>	
3. NAME OF DECEASED (Type or print) <u>MARSHALL</u> First Middle Last <u>G. Henderson</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-01</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William George Henderson</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Garner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Gladys Henderson</u>		Address <u>College Park, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-8</u> , 19 <u>59</u> , to <u>11-18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-18</u> , 19 <u>59</u> , and that death occurred at <u>11:20</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rowland F. Wilkinson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4404 Queensbury Road 11-19-59</u>	
PHYSICIAN'S NAME (Type) <u>Rowland F. Wilkinson</u>		<u>Roadside, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Nov 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Maryland.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12889

CERTIFICATE OF DEATH

Reg. Dist. No.

12883

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 Hr. 10Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elaine F. Middle Hickey Last Hickey				4. DATE OF DEATH Month November Day 6 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/46		9. AGE (In years last birthday) 12 yrs.	IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	IF UNDER 24 HRS. Months 12 Days 12 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY Student		11. BIRTHPLACE (State or foreign country) Maryland Conn.	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Edward D. Hickey				14. MOTHER'S MAIDEN NAME Evelyn T. Kosky			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
INFORMANT D. Hickey Address Edward (Father) Address same as # 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive left intra cerebral 331X DUE TO intra ventricular & subarachnoid 2 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Removal of large DUE TO (c) Removal of large							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11-6-59 to 11-6-59 , that I last saw the deceased alive on November 6, 1959 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Etienne				ADDRESS (Street, city or town, state) 4713 - Bryn Mawr Rd College Park Md DATE SIGNED 11-6-59			
PHYSICIAN'S NAME (Type) Dr. Etienne							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 11/10/59		22c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven Cemetery		22d. LOCATION (City, town, or county) (State) Wheaton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR NOV 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

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1524

• **Non-Compete Clause:** A provision in the contract that prohibits the employee from working for a competitor or starting a competing business within a certain geographic area and time frame after leaving the company.

Volume 7, Number 1

James A. Jones, Jr.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12884

12890

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clyde D Holmes		4. DATE OF DEATH Month Day Year November 1 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/59
9. AGE (In years last birthday) yrs. 14		10. IF UNDER 1 YEAR Months Days Hours Min. 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Vincent Holmes		14. MOTHER'S MAIDEN NAME Clara (nee Hamilton)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Clara- Mother Address same as above.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 764.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) plethoric (c) hear. hear.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2 Inter-ventricular septal defect.			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19d. (City or town) (County) (State)	
20. I certify that I attended the deceased from Oct 30, 19 59 to Nov 1, 59, that I last saw the deceased alive on November 1, 59, and that death occurred at 10:10 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Bertha VanGelderren		DATE SIGNED ADDRESS (Street, city or town, state) 3001 Cheverly Ave, Cheverly, Md. 11/3/59	
PHYSICIAN'S NAME (Type) Bertha VanGelderren, M. D.		3001 Cheverly Ave., Cheverly, Md.	
21. BURIAL, CREMATION, REMOVAL (Specify) Burial		22. DATE THEREOF 11/3/59	
23. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		24. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		26. REC'D BY REGISTRAR NOV 4 '59	
27. REGISTRAR'S SIGNATURE		28. REGISTRAR'S SIGNATURE	

2077246XV6

CERTIFICATE OF DEATH

1920

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Name of physician

6. Name of informant

Handwritten signature

7. Name of registrar

8. Name of registrar
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12885

12891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ieland Memorial Hospital</u>				d. STREET ADDRESS <u>5411 Taylor Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gregory</u> Middle <u>Horan</u> Last <u>Horan</u>				4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-3-53</u>	
9. AGE (In years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Horan</u>				14. MOTHER'S MAIDEN NAME <u>Helen Blackburn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Helen Horan; same address as # 2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO (c) <u> </u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>812x</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by automobile while walking home from school.</u>			
20c. TIME OF INJURY Month, Day, Year <u>3.00</u> a. m. <u>11-25-59</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) <u>Riverdale</u> (County) <u>Pr. Geo.</u> (State) <u>Md.</u>				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>November 25, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>NOV. 28 1959 BURIAL</u>		22b. DATE THEREOF <u> </u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WHEATON, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Don. DeVol</u>				ADDRESS <u>2224-WIS. AVE D.C.</u>		24a. REC'D BY REGISTRAR <u>NOV 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. L. S. Kraus</u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

12938

CERTIFICATE OF DEATH

12886

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park	c. LENGTH OF STAY IN 1b 2 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANGLEY PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1302 Merimac Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle ROSALIE Last HOWARD		4. DATE OF DEATH Month 11 Day 8 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 9, 1870
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DeWitt Teeple		14. MOTHER'S MAIDEN NAME Mary Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Pearl Handiboe, 1302 Merimac Drive		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency (Nephria) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 59 , to Nov , 19 59 , that I last saw the deceased alive on Nov 7 , 19 59 , and that death occurred at 8:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard A Fitzgerald		ADDRESS (Street, city or town, state) 217 University Blvd E.	
PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		DATE SIGNED 11-8-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/12/59	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE NOV 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12887

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Woodmore Road			
3. NAME OF DECEASED (Type or print) First Pearl Middle Geneva Last Hutchinson				4. DATE OF DEATH Month November Day 19 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Oct. 10, 1912		9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 47 Days 47 Hours 47 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Tenant		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles Hutchinson			
14. MOTHER'S MAIDEN NAME Mary Windsor				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO.		17. INFORMANT Emory R. Hutchinson; same address as # 2.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiac asthma Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>John T. Maloney</i>		EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED November 19, 1959		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF 11/23/59		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) Bladensburg, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Brothers		ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE NOV 25 '59			
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thraus</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12888

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 1/2 day		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp.		d. STREET ADDRESS 1413 57th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FLORINE JENKINS		4. DATE OF DEATH Nov. 3 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 June 1912 1911
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert L. Wilson		14. MOTHER'S MAIDEN NAME Mamie Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Arthur C. Jenkins (Husband)		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous intracranial hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4 Nov. 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-7-59	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE L.B. Cameron + Son		24a. REC'D BY REGISTRAR NOV 12 '59	
ADDRESS 6114 St. N.W.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		1/15/1900	
Place of Birth		Race		Occupation		Cause of Death	
New York		White		Teacher		Heart Disease	
Usual Residence		Present Residence		Manner of Death		Signature of Examiner	
123 Main St.		456 Oak St.		Natural		J. H. Smith	
Date of Burial		Place of Burial		Signature of Coroner		Signature of Physician	
1/20/1900		St. Mary's Church		W. J. Brown		D. E. White	
Signature of Informant		Relationship		Signature of Physician		Signature of Coroner	
M. J. Green		Son		D. E. White		J. H. Smith	
Signature of Coroner		Signature of Physician		Signature of Informant		Signature of Burial Officer	
J. H. Smith		D. E. White		M. J. Green		W. J. Brown	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12894

CERTIFICATE OF DEATH

Reg. Dist. No.

12889

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 4003 Webster St.	
3. NAME OF DECEASED (Type or print) First Middle Last Alberta Johnson				4. DATE OF DEATH Month Day Year Nov. 22, 19 59			
5. SEX Fem.		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7/9/1909	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) G.H. I Chairman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, d.c.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Albert Dorsey				14. MOTHER'S MAIDEN NAME Joesphine Grant Simms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. INFORMANT Mrs. Mary G. Spriggs 18- T St. N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Hypertensive Cardio-vascular Disease DUE TO (c) 10 years							INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11-13 , 19 59 , to 11-22 , 19 59 , that I last saw the deceased alive on 11-21 , 19 59 , and that death occurred at 2:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ronald S. Fleischer M.D.				ADDRESS (Street, city or town, state) 5432 Greens Chapel Rd DATE SIGNED 11/22/59			
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER							
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/25/59 Nat. Harmony Park Wash.		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. N. Horton Co. 1322 1st St				24a. REC'D BY REGISTRAR DATE NOV 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

12250

CERTIFICATE OF DEATH

12250



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film G252 11-23-59 et
12939
CERTIFICATE OF DEATH

12890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Accokeek</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Accokeek, MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NONE</u>				d. STREET ADDRESS <u>1 HWY. #283</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Johnson</u>				4. DATE OF DEATH Month Day Year <u>11-16-1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 10 1873</u>	
9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Simon Robinson</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA GITTINGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. COLEMAN BADO 470 WESTMORLAND AVE. TAKOMA PK, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBROSCLEROSIS</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-7-</u> , 19 <u>57</u> , to <u>11-16-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-16-</u> , 19 <u>59</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Chen</u> M.D.				DATE SIGNED <u>Accokeek, MD.</u>			
PHYSICIAN'S NAME (Type) <u>PAUL CHEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 19, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. CNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u> ADDRESS <u>816 H St. N.E. WASH. 2, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	

12200

CERTIFICATE OF DEATH

0032

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1910</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Md</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1935</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>Dec 10 1955</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>16. SIGNATURE OF WITNESS <i>John Doe</i></p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12854

CERTIFICATE OF DEATH

12891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>W. George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>C.E.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PAINT BRANCH Nursing Home</u>				d. STREET ADDRESS <u>2708-30th St. S.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>IZOLA</u> Middle <u>B</u> Last <u>KENNEDY</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-18-87</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>59</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Ralph Kennedy 2708-30th St. S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Visceral Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 yrs +</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease, Diabetes, Rheum. Arthritis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>10/14</u> , 19 <u>58</u> , to <u>11/24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/22</u> , 19 <u>59</u> , and that death occurred at <u>6:15</u> P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>3501 Hamilton St</u>				DATE SIGNED <u>11/24/59</u>			
ACTUAL SIGNATURE <u>Frank M. Trozzo, Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>FRANK M. TROZZO JR MD</u>				<u>Hyattsville Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Blacksburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>517-11th St. S.E. Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12892

12895

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 6600 D'Arcy Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HERMAN Middle C. Last KLEIN		4. DATE OF DEATH Month November Day 5th , Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. Married NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 15th, 1895
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Cemetery	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW1		16. SOCIAL SECURITY NO. 1918-1919 577-16-2806A	
17. INFORMANT William W. Edmunds, 5231 St. Barnabas Rd. S.E.		Address Wash. 21, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio vasoular renal disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>		DATE SIGNED 11/6/1959	
EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/10/1959	22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery	22d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE NOV 10 '59	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12888

NAME OF DECEASED: George James George

RESIDENCE: Westville

DATE OF DEATH: Jan. 18, 1888

PLACE OF DEATH: Home

AGE: 65

SEX: Male

CAUSE OF DEATH: Heart failure

CHARACTER OF DEATH: Accidental

DECEASED'S OCCUPATION: None

DECEASED'S RELIGION: None

DECEASED'S COLOR: White

DECEASED'S BUILD: Medium

DECEASED'S COMPLEXION: Light

DECEASED'S HAIR: Light

DECEASED'S EYES: Light

DECEASED'S MOUTH: Light

DECEASED'S NOSE: Light

DECEASED'S EARS: Light

DECEASED'S TEETH: Light

DECEASED'S SKIN: Light

DECEASED'S FINGERS: Light

DECEASED'S TOES: Light

DECEASED'S NAILS: Light

DECEASED'S HAIR: Light

DECEASED'S EYES: Light

DECEASED'S MOUTH: Light

DECEASED'S NOSE: Light

DECEASED'S EARS: Light

DECEASED'S TEETH: Light

DECEASED'S SKIN: Light

DECEASED'S FINGERS: Light

DECEASED'S TOES: Light

DECEASED'S NAILS: Light

DECEASED'S HAIR: Light

DECEASED'S EYES: Light

DECEASED'S MOUTH: Light

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G252 11-27-59 et

CERTIFICATE OF DEATH

12893

Reg. Dist. No.

12896

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville P.O. d. STREET ADDRESS 5321 Greenway Driver e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle William Last Kreamer			4. DATE OF DEATH Month Nov Day 18 Year 1959				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 7 Feb 1907		9. AGE (In years last birthday) 53 1/2 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Washington, D.C.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Charles Kreamer			
14. MOTHER'S MAIDEN NAME Daisy Mary Dove				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 577-10-8365		INFORMANT Margaret A. Kreamer, 5321 Greenway Drive					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. And Malnutrition, metabolic acidosis (b) Esophagospasm, Chronic (c) 1 yr. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 days INTERVAL BETWEEN ONSET AND DEATH 2 wks 1 yr.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 19 57 to Nov. 18 19 59 that I last saw the deceased alive on Nov 18 1959 , and that death occurred at 6:00 AM , from the causes and on the date stated above. ACTUAL SIGNATURE William Rosson M.D. M.D. 5304 Annapolis Road 11/18/59 PHYSICIAN'S NAME (Type) Dr. William Rosson ., M.D. Bladensburg, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR NOV 23 '59			
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas				25. LOCATION (City, town, or county) (State) Washington, D.C.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• 24 •

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

7239-21-17

Teacher's Company, Riverdale, Md.

12855

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>6 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>15 Hyattsville,</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>814 Talbert Lane.</i>				d. STREET ADDRESS <i>1814 Talbert Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lucy</i> Middle <i>Eleanor</i> Last <i>Kuhn.</i>				4. DATE OF DEATH Month <i>November</i> Day <i>6</i> Year <i>1959</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 1, 1869</i>		9. AGE (In years last birthday) yrs. <i>90</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired photographer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Photography.</i>		11. BIRTHPLACE (State or foreign country) <i>Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Joshua Jones.</i>				14. MOTHER'S MAIDEN NAME <i>Mary Ann Bullers.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>none.</i>		INFORMANT <i>Mrs. M. Campbell.</i>		Address <i>814 Talbert Lane.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Congestive Heart failure.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease.</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>10 days.</i> <i>30 yrs.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>chronic. Bronchitis.</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept. 28, 1959</i> to <i>Nov. 6, 1959</i> that I last saw the deceased alive on <i>Nov 6</i> , 1959, and that death occurred at <i>8:30 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles W. Humphreys, Jr.</i> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <i>1746 K St. N.W. Wash. D.C. 11/6/59</i>			
PHYSICIAN'S NAME (Type) <i>Charles W. Humphreys, Jr.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>11/8/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Brookville Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Brookville, Pennsylvania</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.-2901 14th St., N.W.</i>				ADDRESS <i>Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>NOV 9 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Reg. Dist. No.

12940

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS AFB WASH 25, D.C.				d. STREET ADDRESS 14 DANBURY STREET, S.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DANIEL GLENN LEMASTER				4. DATE OF DEATH Month Day Year NOVEMBER 25 1959			
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 NOV 1959	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JAMES A. LEMASTER				14. MOTHER'S MAIDEN NAME ALICE KISER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. N/A		INFORMANT Address HOSPITAL CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 763.0 Right middle lobe lobar pneumonia DUE TO (b) Undertermined Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 November, 1959, to 25 November, 1959, that I last saw the deceased alive on 25 November 1959, and that death occurred at 1135A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Salvatore Battiatto</i> M.D. USAF HOSP ANDREWS AFB WASH 25, D.C. PHYSICIAN'S NAME (Type) SALVATORE BATTIATA CAPT USAF MC USAF HOSP ANDREWS AFB WASH 25, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 30, 1959		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kinelli Funeral Home 816 H St. N.E. Wash 25, D.C.				24. REC'D BY REGISTRAR DATE NOV 30 '59		24b. REGISTRAR'S SIGNATURE C. L. S. Frank	

2050263XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13980

DECLARATION OF DEATH

13980

DEPARTMENT OF HEALTH

STATE OF NEW YORK

DECLARATION OF DEATH

DATE

TIME

IN COUNTY OF ...

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DECLARED BY

Signature
Signature

NOTED

FILED

DATE

TIME

PLACE

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle L Last Lowery		4. DATE OF DEATH Month Nov. Day 8 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Sept. 1886
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sylvester Emerich		14. MOTHER'S MAIDEN NAME Genevieve Speelman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 420.1	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Nov. , 19 59 , to 8 Nov. , 19 59 , that I lost saw the deceased alive on 8 Nov. , 19 59 , and that death occurred at 12.30A , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman D. Comeau M.D.		ADDRESS (Street, city or town, state) 3503 Perry St. DATE SIGNED 11/8/59	
PHYSICIAN'S NAME (Type) Dr. Norman Comeau, M.D.		Mt. Rainier, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/59	
22c. NAME OF CEMETERY OR CREMATORY St. Vincent's Cem.		22d. LOCATION (City, town, or county) (State) Colman, Md	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Macalister		ADDRESS Laurel, Md	
24a. REC'D BY REGISTRAR DATE NOV 13 '59		24b. REGISTRAR'S SIGNATURE Carling L. R...	

1

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VS A15 (4)
15M 9/58

12345

UNITED STATES DEPARTMENT OF THE INTERIOR

GENERAL LAND OFFICE

1888

[Faint, mostly illegible text and signatures follow, appearing to be a land grant or survey document.]

1

12898

Reg. Dist. No.

12898

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		d. STREET ADDRESS Box 430		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Prince George General		First Ira		Middle J		Last Lynch		4. DATE OF DEATH Month Nov		Day 14		Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 6, 1885		9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months 7		IF UNDER 24 HRS. Days 14		Hours 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A									
13. FATHER'S NAME Edward Lynch		14. MOTHER'S MAIDEN NAME Mary Cummings													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT A.A. Tippet, Nephew,		Address Same									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO (c) arterio-sclerotic heart disease Cancer of prostate		INTERVAL BETWEEN ONSET AND DEATH													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5		20f. (City or town) Bladensburg, Md.		(County) Prince George's		(State) Md.					
21. I certify that I attended the deceased from Nov. 14, 1959 to Nov. 14, 1959 , that I last saw the deceased alive on Nov. 13, 1959 , and that death occurred at 1:20 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1432 Queen Chapel Rd		DATE SIGNED Nov 14 1959											
ACTUAL SIGNATURE Ronald S. Fleischer		M.D. Ronald S. Fleischer													
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 17, 1959		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) Bladensburg, Md.		(State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Francis Buck's Sons		ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE NOV 17 '59		24b. REGISTRAR'S SIGNATURE Arthur & Thomas									

CHIEF OF POLICE

CERTIFICATE OF DEATH

1930

Name of deceased _____

Age _____

Sex _____

Color _____

Place of birth _____

U.S. Government _____

City _____

State _____

County _____

Married _____

Signature of physician _____

Signature of coroner _____

Signature of registrar _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12899

CERTIFICATE OF DEATH

Reg. Dist. No.

12899

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Day		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier		d. STREET ADDRESS 3713 34th St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edward Franklin Malay		4. DATE OF DEATH Month Day Year 11-19-59		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4-6-05		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Washington Post		11. BIRTHPLACE (State or foreign country) Gloucester Co. Va		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Alexander J. Malay		14. MOTHER'S MAIDEN NAME Virgil Mary Gwynn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 2-28-03-4128		INFORMANT Mary R. Poland,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Adrenal insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lobar pneumonia (left upper lobe) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple pulmonary infarctions, right lung		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 17 , 19 59 , to Nov. 19 , 19 59 , that I last saw the deceased alive on Nov. 19 , 19 59 , and that death occurred at 8:02 P. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 3308 Perry St, Mt. Rainier Md.		DATE SIGNED 11/20/59		ACTUAL SIGNATURE Charles C. Hageage		PHYSICIAN'S NAME (Type) Dr. Charles Hageage		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/23/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home Mt. Rainier Md.		ADDRESS Malley's Funeral Home Mt. Rainier Md.		24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneer											

2

077

1

CERTIFICATE OF DEATH

12208

2

1

12941

CERTIFICATE OF DEATH

Reg. Dist. No. 12900

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHILLUM		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum, Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) 722 Rittenhouse Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NICOLA VICTOR MANGO		4. DATE OF DEATH Month Day Year NOV. 29 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 10, 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothes Designer		10b. KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Mango		14. MOTHER'S MAIDEN NAME Concetta Salerno	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 142-05-1395	
17. INFORMANT Pasqualine Mango		Address 722 Rittenhouse St. Chillum, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) 10 months 10 years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 1957 , to NOV. 29, 1959 , that I last saw the deceased alive on NOV. 28, 1959 , and that death occurred at 9:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William F. Simpson Jr. M.D. 6216 N.H. Ave NE		PHYSICIAN'S NAME (Type) William F. Simpson Jr. Washington D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/2/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Colman Manor, Md
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home		ADDRESS Mt. Rainier Md.	
24a. REC'D BY REGISTRAR DATE DEC 2 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 26 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Oakland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6512 - Marlboro Rd. N.E.				d. STREET ADDRESS 16512 - Marlboro Rd. N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First: Nellie Middle: Elizabeth Last: Maske				4. DATE OF DEATH Month: Nov. Day: 9 Year: 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1886	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months: Days: Hours: Min.	IF UNDER 24 HRS. Months: Days: Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Gum Store		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Bair				14. MOTHER'S MAIDEN NAME Elizabeth Pfeffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Magdalen Robinson, 17212 Landon Dr. S.W. Springfield			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Congestive heart failure (b) Cardiac renal disease (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Nov 9, 1959			
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-59		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co Inc, Washington, D.C.				24a. REC'D BY REGISTRAR DATE NOV 16 '59		24b. REGISTRAR'S SIGNATURE C. H. & H. H.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

Coroner's heart failure
Coroner's medical record shows

deceased

James H. Jones
JANES I. JONES

W.D. 1221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12902

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE c. LENGTH OF STAY IN 2 YEARS 11 MO d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FORESTVILLE NURSING HOME		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights d. STREET ADDRESS 5918-ST. CHAIR DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES MONROE McCauley		4. DATE OF DEATH NOV-2-1959			
5. SEX MALE	6. COLOR, OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 6, 1876	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES M. McCauley		14. MOTHER'S MAIDEN NAME NANCY Riggsby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		INFORMANT Bessie L. McCauley Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIO SCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 5 days 15 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 4-3 , 19 53 , to 11-2 , 19 59 , that I last saw the deceased alive on 11-1 , 19 59 , and that death occurred at 12:30 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE John B Fegan		ADDRESS (Street, city or town, state) 2210 NICHOLS AVE S.E		DATE SIGNED	
PHYSICIAN'S NAME (Type) JOHN B FEGAN, M.D.		M.D. WASH D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 5-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Smithland, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE SIMMONS BROS		ADDRESS 1661 Good Hope Rd SE		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Fegan					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12903

Reg. Dist. No.

12900

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. d. STREET ADDRESS 1413 Boones Hill Road, Apt.#1	
3. NAME OF DECEASED (Type or print) EDWARD JOSEPH MC GEE, JR.		4. DATE OF DEATH Month November Day 27th Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 24th, 1914
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Attendant		10b. KIND OF BUSINESS OR INDUSTRY Gasoline	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Joseph McGee		14. MOTHER'S MAIDEN NAME Elizabeth Liversedge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-01-8394	
17. INFORMANT Edward J. McGee 111, 1413 Boones Hill Rd.S.E.		Address Washington 27, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 410X DUE TO Conditions, if any, which gave rise to immediate cause (b) Ulcerated mitral stenosis (c) Ulcerated mitral stenosis DUE TO cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 30, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE DEC 1 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12904**

12856

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3513 54th Avenue				d. STREET ADDRESS 3513 54th Avenue	
3. NAME OF DECEASED (Type or print) Juanita Crenshaw McKibben			4. DATE OF DEATH Month November Day 5 Year 19 59		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-27		9. AGE (In years last birthday) 32 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. Carolina	
13. FATHER'S NAME John Samuel Crenshaw			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 248-34-2563		
17. INFORMANT William B. McKibben; same address as #2.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and shock 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gunshot wound of chest DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted wound of chest			
20c. TIME OF INJURY Month, Day, Year 10.30 A.M. 11-5-1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
		20f. (City or town) Hyattsville		(County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 5, 1959		
22a. REMOVAL, REMOVAL (Specify) Removal		22b. DATE THEREOF Nov. 9, 1959		22c. NAME OF CEMETERY OR CREMATORY Unity Cemetery	
				22d. LOCATION (City, town, or county) (State) Ft. Mill So. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville, Md.		
24a. REC'D BY REGISTRAR DATE NOV 10 '59			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

KENTUCKY STATE DEPARTMENT OF HEALTH - BATHING 18

12000

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
John A. Jones		35		Male		White		10-1-20	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
2145 Avenue A		Teacher		Heart Disease		Natural		Home	
CITY		COUNTY		STATE		FEDERAL DISTRICT		CONGRESSIONAL DISTRICT	
Cincinnati		Hamilton		Ohio		Southern		1	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE	
10-1-20		10:00 AM		Home		J. A. Jones		Physician	
DATE OF INTERVIEW		TIME OF INTERVIEW		PLACE OF INTERVIEW		SIGNATURE OF INTERVIEWER		TITLE	
10-1-20		10:00 AM		Home		J. A. Jones		Physician	
DATE OF BURIAL		TIME OF BURIAL		PLACE OF BURIAL		SIGNATURE OF BURIAL OFFICER		TITLE	
10-1-20		10:00 AM		Home		J. A. Jones		Physician	



CERTIFICATE OF DEATH

Reg. Dist. No. 12905

12901

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Barbara Mc Kinney				4. DATE OF DEATH November 13 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18 1959		9. AGE (In years last birthday) 5	IF UNDER 1 YEAR 5 Months 13 Days 19 Hours 59 Min.	IF UNDER 24 HRS. 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME Robert L. Mc Kinney				14. MOTHER'S MAIDEN NAME Dorothy Godsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None			16. SOCIAL SECURITY NO. Dorothy Mother		17. ADDRESS 6300 Riverdale Rd., Riverdale Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacteremia & Hydrocephalus 512.1 DUE TO Resilient Shunt & acute bronchitis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) acute bronchitis (c) acute bronchitis							INTERVAL BETWEEN ONSET AND DEATH 5 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from June 18 1959 to November 13 1959 , that I last saw the deceased alive on November 13 1959 , and that death occurred at 6:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William A. Stecher MD				ADDRESS (Street, city or town, state) 6300 Riverdale Rd., Riverdale Md.			
PHYSICIAN'S NAME (Type) William A. Stecher				DATE SIGNED 11/18/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 16, 1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR NOV 17 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Knecht			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077384XV4

CERTIFICATE OF DEATH

1901

State of Tennessee
County of _____
I, _____, Clerk of the County,
do hereby certify that _____
of the County of _____
State of Tennessee,
born _____
died _____
at _____
Tennessee,
on the _____ day of _____
1901,
at the age of _____ years,
cause of death _____
Buried _____
at _____
Tennessee.

Witness my hand and the seal of the County
at _____
Tennessee,
this _____ day of _____
1901.

Clerk of the County

Minister of the Gospel

Pastor of the _____
Church of the _____
at _____
Tennessee.

Minister of the Gospel

Pastor of the _____
Church of the _____
at _____
Tennessee.

Minister of the Gospel

Pastor of the _____
Church of the _____
at _____
Tennessee.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 Collige Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp</u>		d. STREET ADDRESS <u>4835 Jordan Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Arthur</u> Last <u>Melton</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-12</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electronics</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Melton</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Dixon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Louise Ligon Collige Park Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO (b) <u>Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Polycystic kidneys, Coronary atherosclerosis</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work <u> </u> Not while <input type="checkbox"/> of work <u> </u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u> </u>		DATE SIGNED <u>Dec-1, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 2, 1959</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>George Washington</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF DEATH: *10/15/1917*

5. PLACE OF DEATH: *Home*

6. CAUSE OF DEATH: *Heart Disease*

7. MANNER OF DEATH: *Natural*

8. SIGNATURE OF EXAMINER: *J. H. Smith*

9. DATE OF EXAMINATION: *10/16/1917*

10. PLACE OF EXAMINATION: *Home*

11. SIGNATURE OF ATTENDING PHYSICIAN: *Dr. J. H. Smith*

12. DATE OF EXAMINATION: *10/16/1917*

13. PLACE OF EXAMINATION: *Home*

14. SIGNATURE OF EXAMINER: *J. H. Smith*

15. DATE OF EXAMINATION: *10/16/1917*

16. PLACE OF EXAMINATION: *Home*

17. SIGNATURE OF EXAMINER: *J. H. Smith*

18. DATE OF EXAMINATION: *10/16/1917*

19. PLACE OF EXAMINATION: *Home*

20. SIGNATURE OF EXAMINER: *J. H. Smith*

21. DATE OF EXAMINATION: *10/16/1917*

22. PLACE OF EXAMINATION: *Home*

23. SIGNATURE OF EXAMINER: *J. H. Smith*

24. DATE OF EXAMINATION: *10/16/1917*

25. PLACE OF EXAMINATION: *Home*

26. SIGNATURE OF EXAMINER: *J. H. Smith*

27. DATE OF EXAMINATION: *10/16/1917*

28. PLACE OF EXAMINATION: *Home*

29. SIGNATURE OF EXAMINER: *J. H. Smith*

30. DATE OF EXAMINATION: *10/16/1917*

31. PLACE OF EXAMINATION: *Home*

32. SIGNATURE OF EXAMINER: *J. H. Smith*

33. DATE OF EXAMINATION: *10/16/1917*

34. PLACE OF EXAMINATION: *Home*

35. SIGNATURE OF EXAMINER: *J. H. Smith*

36. DATE OF EXAMINATION: *10/16/1917*

37. PLACE OF EXAMINATION: *Home*

38. SIGNATURE OF EXAMINER: *J. H. Smith*

39. DATE OF EXAMINATION: *10/16/1917*

40. PLACE OF EXAMINATION: *Home*

41. SIGNATURE OF EXAMINER: *J. H. Smith*

42. DATE OF EXAMINATION: *10/16/1917*

43. PLACE OF EXAMINATION: *Home*

44. SIGNATURE OF EXAMINER: *J. H. Smith*

45. DATE OF EXAMINATION: *10/16/1917*

46. PLACE OF EXAMINATION: *Home*

47. SIGNATURE OF EXAMINER: *J. H. Smith*

48. DATE OF EXAMINATION: *10/16/1917*

49. PLACE OF EXAMINATION: *Home*

50. SIGNATURE OF EXAMINER: *J. H. Smith*

51. DATE OF EXAMINATION: *10/16/1917*

52. PLACE OF EXAMINATION: *Home*

53. SIGNATURE OF EXAMINER: *J. H. Smith*

54. DATE OF EXAMINATION: *10/16/1917*

55. PLACE OF EXAMINATION: *Home*

56. SIGNATURE OF EXAMINER: *J. H. Smith*

57. DATE OF EXAMINATION: *10/16/1917*

58. PLACE OF EXAMINATION: *Home*

59. SIGNATURE OF EXAMINER: *J. H. Smith*

60. DATE OF EXAMINATION: *10/16/1917*

61. PLACE OF EXAMINATION: *Home*

62. SIGNATURE OF EXAMINER: *J. H. Smith*

63. DATE OF EXAMINATION: *10/16/1917*

64. PLACE OF EXAMINATION: *Home*

65. SIGNATURE OF EXAMINER: *J. H. Smith*

66. DATE OF EXAMINATION: *10/16/1917*

67. PLACE OF EXAMINATION: *Home*

68. SIGNATURE OF EXAMINER: *J. H. Smith*

69. DATE OF EXAMINATION: *10/16/1917*

70. PLACE OF EXAMINATION: *Home*

71. SIGNATURE OF EXAMINER: *J. H. Smith*

72. DATE OF EXAMINATION: *10/16/1917*

73. PLACE OF EXAMINATION: *Home*

74. SIGNATURE OF EXAMINER: *J. H. Smith*

75. DATE OF EXAMINATION: *10/16/1917*

76. PLACE OF EXAMINATION: *Home*

77. SIGNATURE OF EXAMINER: *J. H. Smith*

78. DATE OF EXAMINATION: *10/16/1917*

79. PLACE OF EXAMINATION: *Home*

80. SIGNATURE OF EXAMINER: *J. H. Smith*

81. DATE OF EXAMINATION: *10/16/1917*

82. PLACE OF EXAMINATION: *Home*

83. SIGNATURE OF EXAMINER: *J. H. Smith*

84. DATE OF EXAMINATION: *10/16/1917*

85. PLACE OF EXAMINATION: *Home*

86. SIGNATURE OF EXAMINER: *J. H. Smith*

87. DATE OF EXAMINATION: *10/16/1917*

88. PLACE OF EXAMINATION: *Home*

89. SIGNATURE OF EXAMINER: *J. H. Smith*

90. DATE OF EXAMINATION: *10/16/1917*

91. PLACE OF EXAMINATION: *Home*

92. SIGNATURE OF EXAMINER: *J. H. Smith*

93. DATE OF EXAMINATION: *10/16/1917*

94. PLACE OF EXAMINATION: *Home*

95. SIGNATURE OF EXAMINER: *J. H. Smith*

96. DATE OF EXAMINATION: *10/16/1917*

97. PLACE OF EXAMINATION: *Home*

98. SIGNATURE OF EXAMINER: *J. H. Smith*

99. DATE OF EXAMINATION: *10/16/1917*

100. PLACE OF EXAMINATION: *Home*

ALL DEATHS MUST BE REPORTED TO THE DEPARTMENT OF HEALTH
WITHIN 24 HOURS OF THE TIME OF DEATH
FAILURE TO DO SO IS A VIOLATION OF THE LAW
AND IS PUNISHABLE BY A FINE OF \$100
OR IMPRISONMENT FOR 30 DAYS
OR BOTH

CERTIFICATE OF DEATH

Reg. Dist. No.

12907

12944

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL- GLENN DALE 7 YRS, 1 Mo, 4 W		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle C. MENDE Last HALL		4. DATE OF DEATH Month NOV Day 21 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/07
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	
11. BIRTHPLACE (State or foreign country) SALISBURY, NORTH CAR.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W. KERR		14. MOTHER'S MAIDEN NAME CLARA SWAIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNK.	
17. INFORMANT PATIENT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) _____ 002X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY INSUFFICIENCY AND COR PULMONALE			INTERVAL BETWEEN ONSET AND DEATH 8 YRS.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from OCT 17, 1952 to NOV 21, 1959 that I last saw the deceased alive on NOV 21, 1959 , and that death occurred at 1100 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Uwe Weiss</i>		DATE SIGNED 11/21/59	
PHYSICIAN'S NAME (Type) MOE WEISS, M.D.		GLENN DALE, M.D.	
22a. (BURIAL) CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 11-23-59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Sacchi		24a. REC'D BY REGISTRAR NOV 27 '59	
ADDRESS 4739 Bell Ave, Hyattsville		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

MOE WEISS, M.D.
GLENN DALE, MD.
GLENN DALE HOSPITAL
NOV 31 21
OCT 17 21
NOV 31 21

PULMONARY INSUFFICIENCY AND CCR PULMONARY

X

PULMONARY TUBERCULOSIS

8 YRS

NO

W.K.

PATIENT

JOHN W. KERR

CLARA SWAIN

SEAMSTRESS SELF-EMPLOYED SALESWOMAN, NORTH CAR. V.2.A.

FEMALE WHITE

X

6/9/07

22

MILLIE C. MENDENHALL

NOV 31

22

GLENN DALE HOSPITAL 3221 CENTER ST. N.W.

X

RURAL - GLENN DALE, KY, IND. DR.

WASHINGTON

PRICE GEORGES

DISTRICT OF COLUMBIA

12945

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton, Maryland		c. LENGTH OF STAY IN lb Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton, Maryland		d. STREET ADDRESS Thrift Road, Clinton, Maryland.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Thrift Road, Clinton, Maryland.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM F. MULLIKIN		4. DATE OF DEATH Month NOV. Day 20th. Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9th. 1900
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 30 Days 30 Hours 30 Min.	11. IF UNDER 24 HRS. Months 30 Days 30 Hours 30 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Campbell's Hardware	
11. BIRTHPLACE (State or foreign country) Clinton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Mullikin		14. MOTHER'S MAIDEN NAME Mary O. Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-07-2249	
INFORMANT Mrs. Alice C. Mullikin		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Cardiac Failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Renal Disease DUE TO (c) Diabetes Mellitus for one year			
INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus for one year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1959 , to Nov 20, 1959 , that I last saw the deceased alive on Nov 15, 1959 , and that death occurred at 3:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5440 Silver Hill Rd SE Washington D.C. DATE SIGNED PAUL C Van Hatten			
ACTUAL SIGNATURE PAUL C Van Hatten M.D.		DATE SIGNED PAUL C Van Hatten	
PHYSICIAN'S NAME (Type) PAUL C Van Hatten		DATE SIGNED PAUL C Van Hatten	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23rd. 59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
ADDRESS 16610 Good Hope Road S.E. Washington 20, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **12909**

12903

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Howard b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) No Laurel 13X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 6th		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First Ereutt Middle Mullis Last Mullis				4. DATE OF DEATH Month Nov Day 14 Year 19 59			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 2, 1959	
9. AGE (In years lost birthday) yrs. 12		IF UNDER 1 YEAR Months 12		IF UNDER 24 HRS. Days 6 Hours 5 Min. 5			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) name			10b. KIND OF BUSINESS OR INDUSTRY name			11. BIRTHPLACE (State or foreign country) Marylan	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Forrest Mullis				14. MOTHER'S MAIDEN NAME Nancy Gail Van Alstine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
(If yes, give war or dates of service)				INFORMANT Parents			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 2 , 19 59 , to Nov 14 , 19 59 , that I last saw the deceased alive on Nov 14 , 19 59 , and that death occurred at 2:25 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 420 1st Main St. DATE SIGNED							
ACTUAL SIGNATURE John R Buell				M.D. Laurel M d.			
PHYSICIAN'S NAME (Type) Dr. John Buell							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/59		22c. NAME OF CEMETERY OR CREMATORY Laurel Cem		22d. LOCATION (City, town, or county) (State) Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. With Canalean				ADDRESS Laurel Md		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE NOV 18 '59 Arthur S. Krawe	

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100-37300

CERTIFICATE OF DEATH

12003

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

100-37300

CERTIFICATE OF DEATH

12003

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

REPORTED BY

SIGNATURE

DATE

PLACE

100-37300

CERTIFICATE OF DEATH

12003

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

REPORTED BY

SIGNATURE

DATE

PLACE

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12904

CERTIFICATE OF DEATH

Reg. Dist. No.

12910

1. PLACE OF DEATH a. COUNTY <u>Prince George Co. MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 Greenbelt</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hosp.</u>				d. STREET ADDRESS <u>1 St. C Ridge Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Michael</u> Last <u>Newcomb</u>				4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-13-99</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>59</u> Days <u>59</u> Hours <u>59</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>line Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C & P Telephone Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Edward Newcomb</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wagner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>420.0</u>		17. INFORMANT <u>Hosp. Record - Leland Memorial Hosp.</u>		Address <u>Hosp. Record - Leland Memorial Hosp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-7-58</u> , 19 <u>58</u> , to <u>11-12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-12</u> , 19 <u>59</u> , and that death occurred at <u>4:50</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. R. Purdie</u>				ADDRESS (Street, city or town, state) <u>4404 Queensbury Rd, Riverdale, Md.</u>			
DATE SIGNED <u>11-12-59</u>							
PHYSICIAN'S NAME (Type) <u>D. R. Purdie MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. G. Dutterly</u>				ADDRESS <u>131-11th St. S.E.</u>		24a. REC'D BY REGISTRAR <u>NOV 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>August</u>							

12946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fairmount Hgts.</i>		c. LENGTH OF STAY IN 1b <i>5 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1032-58" Ave.</i>		d. STREET ADDRESS <i>1032-58" Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Bertha Nelson Davis</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>30</i> Year <i>1959</i>	
5. SEX <i>fe</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-3-1909</i>
9. AGE (In years last birthday) <i>50</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Berry</i>		14. MOTHER'S MAIDEN NAME <i>Bertha Irene Forrest</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Ethel M. Davis</i>		Address <i>4020 Ala. Ave. S.E.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X Cardio-Vascular (Hypertension) Hemorrhage</i> DUE TO (b) <i>Hypertensive Cardio-Vascular Disease</i> DUE TO (c) <i>C.V.A. Hemorrhage 10/18/59</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>25</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-20-</i> , 19 <i>59</i> , to <i>11-30-</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11-20-</i> , 19 <i>59</i> , and that death occurred at <i>2: P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Robinson</i>		ADDRESS (Street, city or town, state) <i>1001 Eastview, N.E.</i>	
PHYSICIAN'S NAME (Type) <i>John W. Robinson, M.D.</i>		DATE SIGNED <i>11/20/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/5/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>WOODLAWN</i>		22d. LOCATION (City, town, or county) (State) <i>WASH., D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Stewart</i>		ADDRESS <i>30 State St.</i>	
24a. REC'D BY REGISTRAR DATE <i>DEC 3 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH



DEATH OF A PERSON WHOSE DEATH IS REPORTED TO THE HEALTH DEPARTMENT BY A PHYSICIAN OR A PERSON WHOSE DEATH IS REPORTED TO THE HEALTH DEPARTMENT BY A PERSON OTHER THAN A PHYSICIAN		DEATH OF A PERSON WHOSE DEATH IS REPORTED TO THE HEALTH DEPARTMENT BY A PHYSICIAN	
NAME OF DECEASED SEX AGE DATE OF BIRTH PLACE OF BIRTH		NAME OF DECEASED SEX AGE DATE OF BIRTH PLACE OF BIRTH	
OCCUPATION EDUCATION MARITAL STATUS COLOR		OCCUPATION EDUCATION MARITAL STATUS COLOR	
PLACE OF DEATH DATE OF DEATH TIME OF DEATH CAUSE OF DEATH		PLACE OF DEATH DATE OF DEATH TIME OF DEATH CAUSE OF DEATH	
SIGNATURE OF PHYSICIAN SIGNATURE OF PERSON REPORTING DEATH		SIGNATURE OF PHYSICIAN SIGNATURE OF PERSON REPORTING DEATH	
CERTIFICATE OF DEATH DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		CERTIFICATE OF DEATH DEPARTMENT OF HEALTH BALTIMORE, MARYLAND	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

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MEDICAL CERTIFICATION
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12912

12858 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier		c. LENGTH OF STAY IN 1b 52 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4208 34th Street			d. STREET ADDRESS 4208 34th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Edward Calvin Norton			4. DATE OF DEATH Month Nov. Day 11 Year 1959		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/06		9. AGE (In years last birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone mason		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Amos Leonard Norton			14. MOTHER'S MAIDEN NAME Grace L.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16. SOCIAL SECURITY NO. 219-03-4331		
17. INFORMANT Bernadine M. Parnell; Riverdale, Md.			Address 5707 Longfellow		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 11/16/59		
22c. NAME OF CEMETERY OR CREMATORY Arlington National			22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home			24a. REC'D BY REGISTRAR DATE NOV 16 '59		
ADDRESS Inc. Md.			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		12-15-1912	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St, Baltimore, Md		Carpenter		Myocardial Infarction		Natural	
Physician		Hospital		Time of Death		Place of Death	
Dr. J. Smith		St. Mary's Hospital		10:30 AM		Hospital	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12913

12905

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NICOLOSON		4. DATE OF DEATH November 5th, 19 59	
5. SEX Male	6. COLOR OF SKIN WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1920
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) GEORGIA
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Idell Ores (Wife)		Address Wash. 341-11th. St. S. E. D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary athero-sclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22b. DATE THEREOF 11-12-59		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN	
22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.		22e. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Rhine</i>		24a. REC'D BY REGISTRAR NOV 12 '59	
ADDRESS Washington D.C.		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1905

THE DEPT. OF HEALTH

NAME OF DECEASED
JAMES J. JONES

RESIDENCE
BALTIMORE, MD.

DATE OF DEATH
JAN. 10, 1905

PLACE OF DEATH
HOME

AGE
45

SEX
MALE

PLACE OF BIRTH
BALTIMORE, MD.

DATE OF BIRTH
JAN. 10, 1860

EDUCATION
HIGH SCHOOL

RELIGION
METHODIST

OCUPATION
CLOCK MAKER

CAUSE OF DEATH
HEART DISEASE

MODE OF DEATH
SUDDEN

PERIOD OF ILLNESS
ONE DAY

DATE OF DEATH
JAN. 10, 1905

LABORATORY
BALTIMORE

CONTESTATION
NONE

TESTS
NONE

TESTS OF VITALITY
NONE

DATE OF DEATH
JAN. 10, 1905

TESTS OF VITALITY
NONE

TESTS OF VITALITY
NONE

TESTS OF VITALITY
NONE

TESTS OF VITALITY
NONE

TESTS OF VITALITY
NONE

TESTS OF VITALITY
NONE

TESTS OF VITALITY
NONE

TESTS OF VITALITY
NONE

TESTS OF VITALITY
NONE

TESTS OF VITALITY
NONE

TESTS OF VITALITY
NONE

TESTS OF VITALITY
NONE

TESTS OF VITALITY
NONE

12947
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)		c. LENGTH OF STAY IN lb 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington St. N.W., Apt. 47X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 813 - 5th St., N.W., Apt. 7			
3. NAME OF DECEASED (Type or print) First James Middle Peatross Last Peatross			4. DATE OF DEATH Month Nov. Day 10 Year 19 59				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/96		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Pittsylvania Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Peatross			14. MOTHER'S MAIDEN NAME Annie Cunningham				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. lost		INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tuberculous peritonitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 days 5 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 23 , 19 59 , to Nov. 10 , 19 59 , that I last saw the deceased alive on November 10 , 19 59 , and that death occurred at 1:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital, Maryland DATE SIGNED 11/10/59 ACTUAL SIGNATURE Moe Weiss M.D. PHYSICIAN'S NAME (Type) Moe Weiss							
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-10-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE George L. Better				24a. REC'D BY REGISTRAR DATE NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1924

COBURN

1000

1000

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12915

12906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> <u>47x-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>1103 50th Place</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Albert</u> Last <u>Pinkney</u>				4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>2-21-1896</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drayage</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Henry Pinkney</u>			
14. MOTHER'S MAIDEN NAME <u>Minnie Hawkins</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			
16. SOCIAL SECURITY NO. <u>W.W. 1 579-01-462</u>		17. INFORMANT Address <u>Beatrice Pinkney; same address as # 2.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>Ruptured heart</u> (c) <u>Cardiovascular renal disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			
22d. LOCATION (City, town, or county) <u>Arlington, Va.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Collins</u>		ADDRESS <u>4339 HuntPl., N.E.</u>		24a. REC'D BY REGISTRAR <u>NOV 23 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>William S. Hunt</u>		24c. REGISTRAR'S SIGNATURE					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		AGE [REDACTED]		SEX [REDACTED]		RACE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CITY [REDACTED]		COUNTY [REDACTED]	
OCCUPATION [REDACTED]		EDUCATION [REDACTED]		MARRIAGE [REDACTED]		RELIGION [REDACTED]	
PREVIOUS ILLNESS [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL OPINION [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF SECOND WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF THIRD WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF FOURTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF FIFTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF SIXTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF SEVENTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF EIGHTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF NINTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	
SIGNATURE OF TENTH WITNESS [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		COUNTY [REDACTED]	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G252 11-16-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12916

12948

1. PLACE OF DEATH o. COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Second Hosp Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Herman</u> Last <u>Proctor</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12th 1883</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	9c. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USIT</u>	
13. FATHER'S NAME <u>Thomas Marcellous Proctor</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth M. Proctor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-01-51789</u>	
17. INFORMANT <u>Daughter, Georgeanna Butler</u>		Address <u>Rt #4 Box 278 Upper Marlboro</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO (b) <u>Post operative supra-</u> c) <u>bic prostatectomy</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11. 8. 59</u> to <u>11. 8. 59</u> , that I last saw the deceased alive on <u>11. 6</u> , 19 <u>59</u> , and that death occurred at <u>7P</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Samadi</u> M.D.		DATE SIGNED <u>11. 8. 59.</u>	
PHYSICIAN'S NAME (Type) <u>A. SAMADI</u>		<u>LEONARDTOWN - Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosaryville Cem</u>	22d. LOCATION (City or town, county, and state) <u>Upper Marlboro Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
DATE <u>NOV 12 '59</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12917

12907

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>15-Geo</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheserly</u>		c. LENGTH OF STAY IN 1b <u>D.O.G.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Sandover</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>			d. STREET ADDRESS <u>Box 648 - A.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Dorothy Ramsey</u>			4. DATE OF DEATH Month <u>Nov</u> - Day <u>22</u> - Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-25-1939</u>		9. AGE (In years last birthday) yrs. <u>22</u> Months <u>27</u> Days <u>27</u> Hours <u>27</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Ramsey</u>			14. MOTHER'S MAIDEN NAME <u>Frances Virginia Kerns</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>John Ramsey - same address.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>November 22, '59.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 24, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>			ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>
					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2077369XU5

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 DEPARTMENT OF HEALTH-BALTIMORE, MD.

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____		SIGNATURE OF CORONER _____	
CITY OF BALTIMORE _____		COUNTY OF BALTIMORE _____		STATE OF MARYLAND _____	

DECEASED
 NAME
 ADDRESS
 CITY
 STATE
 ZIP

This certificate is to be filled out by the Medical Examiner or Coroner of the jurisdiction in which the death occurred. It is to be filed with the local health department and a copy sent to the State Department of Health.

12908

CERTIFICATE OF DEATH

12918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 0 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Parkway Estates d. STREET ADDRESS 4826 67th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Laura Ann Rasmussen		4. DATE OF DEATH Month Day Year Nov. 8 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 15, 1959
9. AGE (In years last birthday) 14 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 14 11 00 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Rasmussen		14. MOTHER'S MAIDEN NAME Mary Hince	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
INFORMANT Father		Address Same as no 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 492X IMMEDIATE CAUSE (a) Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on Nov 8 , 19 59 , and that death occurred at 9:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bertha Van Gelderen		ADDRESS (Street, city or town, state) 3001 Cheverly Ave Cheverly, Md	
PHYSICIAN'S NAME (Type) Bertha Van Gelderen		DATE SIGNED 11/14/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF nov 12, 1959	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE NOV 13 '59		24b. REGISTRAR'S SIGNATURE Arthur G. Hines	

2077322XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12908

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of ...

Decedent's name ...

Place of birth ...

Age ...

Sex ...

Color ...

Marital status ...

Occupation ...

Cause of death ...

Signature of physician ...

Witness ...

Filed for record ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12857 CERTIFICATE OF DEATH

12919

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ohio</u> b. COUNTY <u>Summit Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>6 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1304 Legation Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Dellice</u> First <u>Rhodes</u> Middle <u>Rhodes</u> Last <u>Rhodes</u>		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refr. School Teacher Akron, O.</u>		9. AGE (In years lost birthday) <u>64</u> yrs.	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u> Hours <u>28</u> Min. <u>59</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Thompson, Ohio</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Guernsey G. Whipple</u>	
14. MOTHER'S MAIDEN NAME <u>Agnes Richards</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>269-12-7904</u>		17. INFORMANT <u>Mr. Jean Crusan 1304 Legation Rd Hyattsville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>155.1 INANITION & CARDIAC FAILURE</u> DUE TO (b) <u>CARCINOMA COMPTON BILE DUCT</u> DUE TO (c) <u>WITH METASTASES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 HOURS</u> <u>12 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 5, 1959</u> to <u>28 NOV. 1959</u> that I last saw the deceased alive on <u>21 NOV. 1959</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry R. Wolfe</u> M.D. <u>905 SHERIDAN ST.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>11/29/59</u>	
PHYSICIAN'S NAME (Type) <u>HENRY R. WOLFE M.D.</u>		<u>HYATTSVILLE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Dec. 1/59</u>		22b. DATE THEREOF <u>mt. Gease</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt. Gease</u>		22d. LOCATION (City, town, or county) (State) <u>Akron Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>		24. REC'D BY REGISTRAR <u>DEC 2 '59</u>	
24a. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE	

12949

CERTIFICATE OF DEATH

Reg. Dist. No.

12920

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS,				d. STREET ADDRESS 2729 TERRACE ROAD SE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DOROTHY Middle M Last SABIN				4. DATE OF DEATH Month NOVEMBER Day 11 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 November 1931		9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) HARTFORD, WISCONSIN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALTHA I. RUBY				14. MOTHER'S MAIDEN NAME OLIVE BREWBAKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 508-34-6302		INFORMANT ROBERT C SABIN(H) Address 2729 Terrace Road Se, Washington 20, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary edema DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Breast carcinoma metastatic to the lung. DUE TO to the lung.							INTERVAL BETWEEN ONSET AND DEATH 45 min 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 NOVEMBER , 19 59 , to 11 NOVEMBER , 19 59 , that I last saw the deceased alive on 11 NOVEMBER , 19 59 , and that death occurred at 10:19 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Murray Shvick				ADDRESS (Street, city or town, state) USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC			
PHYSICIAN'S NAME (Type) MURRAY P. SHEVICK CAPT USAF MC				ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 11-12-59		22c. NAME OF CEMETERY OR CREMATORY LEE'S CREMATORY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE M. J. Rinaldi				ADDRESS 816 H ST. N.E. WASH. 2, D.C.		24a. REC'D BY REGISTRAR NOV 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

4

1902

Blank certificate form with horizontal lines for text entry.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registering officer for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12921

12909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur Charles Schalk</u>		4. DATE OF DEATH <u>Nov 14 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR <u>63</u> Months <u>14</u> Days <u>19</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Special Police - U.S. Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Schalk</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Wentz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.-1</u>	
17. INFORMANT <u>Ethel Schalk</u>		Address <u>Same address as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY - M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home</u>		24. REGISTRAR'S SIGNATURE <u>Arthur S. Kead</u>	
ADDRESS <u>Mt. Rainier Md.</u>		DATE <u>NOV 18 1959</u>	

15051
MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>10/15/1918</i>		6. TIME OF DEATH <i>10:30 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. MANNER OF DEATH <i>Natural</i>		10. SIGNATURE OF EXAMINER <i>Dr. J. H. Smith</i>	
11. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		12. SIGNATURE OF WITNESSES <i>John Doe, Mary Doe</i>	
13. SIGNATURE OF CLERK <i>John Doe</i>		14. SIGNATURE OF JURY <i>John Doe, Mary Doe</i>	
15. SIGNATURE OF JUDGE <i>John Doe</i>		16. SIGNATURE OF SHERIFF <i>John Doe</i>	
17. SIGNATURE OF CORONER <i>John Doe</i>		18. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>	
19. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>		20. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>	
21. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>		22. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>	
23. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>		24. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>	
25. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>		26. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>	
27. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>		28. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>	
29. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>		30. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>	
31. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>		32. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>	
33. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>		34. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>	
35. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>		36. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>	
37. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>		38. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>	
39. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>		40. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>	
41. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>		42. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>	
43. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>		44. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>	
45. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>		46. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>	
47. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>		48. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>	
49. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>		50. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>	
51. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>		52. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>	
53. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>		54. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>	
55. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>		56. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>	
57. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>		58. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>	
59. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>		60. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>	
61. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>		62. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>	
63. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>		64. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>	
65. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>		66. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>	
67. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>		68. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>	
69. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>		70. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>	
71. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>		72. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>	
73. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>		74. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>	
75. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>		76. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>	
77. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>		78. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>	
79. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>		80. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>	
81. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>		82. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>	
83. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>		84. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>	
85. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>		86. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>	
87. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>		88. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>	
89. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>		90. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>	
91. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>		92. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>	
93. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>		94. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>	
95. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>		96. SIGNATURE OF DEPUTY JURY <i>John Doe, Mary Doe</i>	
97. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i>		98. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>	
99. SIGNATURE OF DEPUTY CORONER <i>John Doe</i>		100. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>	

15051
MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 FilmG251 11-10-59 et
12910
CERTIFICATE OF DEATH

12922

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eunice Middle E Last Shaver		4. DATE OF DEATH Month Nov. Day 1 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/08
9. AGE (In years last birthday) 50 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME A. M. Mc Comas		14. MOTHER'S MAIDEN NAME Vesta Nelson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Delbert E Shaver		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Mitral Stenosis & Patent Foramen Ovale DUE TO (c) Chronic Rheumatic Heart Disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pulmonary Emphysema due to Chronic Bronchitis		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 56 to Nov. 1 , 19 59 that I last saw the deceased alive on November 1 , 19 59 , and that death occurred at 1:25P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William D Rosson M.D. Dr. Rosson, M.D.		ADDRESS (Street, city or town, state) 5304 Annapolis Road Bladensburg, Maryland	
PHYSICIAN'S NAME (Type) Dr. Rosson, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/59	
22c. NAME OF CEMETERY OR CREMATORY Kessler Funeral Home		22d. LOCATION (City, town, or county) (State) Akron Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR NOV 5 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

20716

• *Not a direct line*

Figure 2. The effect of the concentration of the

2414

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12923

12950

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights Md		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8515 60th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Last Smith		4. DATE OF DEATH Month November Day 25 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 30, 1873
9. AGE (In years last birthday) 86 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ? Clodgett		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Paul J Mc Cullough		Address Berwyn Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Hypocreted Infarction DUE TO (b) Chronic Interstitial Nephritis DUE TO (c) Generalized Interstitial Nephritis		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypocreted Infarction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 25, 1959 to Nov 25, 1959 , that I last saw the deceased alive on Nov 25, 1959 , and that death occurred at Nov 25, 1959 , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Nov 25, 1959	
ACTUAL SIGNATURE Robert C Wingfield		DATE SIGNED Nov 25, 1959	
PHYSICIAN'S NAME (Type) Robert C Wingfield		Laurel, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 28, 1959	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR NOV 30 '59		24b. REGISTRAR'S SIGNATURE C. L. S. Kline	

CERTIFICATE OF DEATH

12050

DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH
SEX	AGE	CAUSE OF DEATH	DIAGNOSIS
EDUCATION	RELIGION	DATE OF BURIAL	PLACE OF BURIAL
NAME OF DECEASED	NAME OF NEXT OF KIN	NAME OF PHYSICIAN	NAME OF MINISTER

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the document.]

CERTIFICATE OF DEATH

12924

Reg. Dist. No.

12951

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47X-3</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendly, Md. (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8320 Old Fort Rd S.E.</u>				d. STREET ADDRESS <u>224 Second St. N.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Eugenia</u> Middle <u>Smith</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR. 30 1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Post Office (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Chicago, Ill.</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Arthur E. Carter</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Allen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Marie E. Murray</u>		17. INFORMANT <u>Marie E. Murray</u> Address <u>3500 Savannah St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>3 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>0</u> p. m. <u>0</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 2, 1959</u> , to <u>Nov. 4, 1959</u> , that I last saw the deceased alive on <u>Nov. 4, 1959</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7519 Broadview Rd S.E.</u>				DATE SIGNED <u>11/4/59</u>			
ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ANNA COYNE TODD</u>				<u>Friendly, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Chicago, Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines & Co.</u> ADDRESS <u>3015-12th St. N.E. Washington D.C.</u>				24a. REC'D BY REGISTRAR <u>NOV 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Adasacorda Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Levy First Newton Middle Stely Last		4. DATE OF DEATH Nov Month 21 Day 1959 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 13, 1868
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Penn.
12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Phillip S. Brooke 4720 Eastern Av. NE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart Failure (b) Arteriosclerotic Heart Disease (c) Generalized Arteriosclerosis DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 yrs + 10 yrs +			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 to 11/20 1959, that I last saw the deceased alive on 11/20 1959, and that death occurred at 935 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M. Trozzo		ADDRESS (Street, city or town, state) 3501 Hamilton St	
PHYSICIAN'S NAME (Type) FRANK M. TROZZO		DATE SIGNED 11/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/59	
22c. NAME OF CEMETERY OR CREMATORY Flint Hill Cem.		22d. LOCATION (City, town, or county) (State) Oakton, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS 4th & Mass Ave. N. E.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
DATE NOV 25 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10 ft. 4 in. *Convolvulus*
 2 ft. 6 in. *Antennaria*
 2 ft. 6 in. *Antennaria*

$\frac{1038}{11/20} = \frac{1038}{11/20}$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12912

CERTIFICATE OF DEATH

12926

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 E. Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		d. STREET ADDRESS <u>5423 55th Pl.</u>	
3. NAME OF DECEASED (Type or print) First <u>Valencia</u> Middle <u>Stewart</u> Last <u></u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-33</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur C Krites</u>		14. MOTHER'S MAIDEN NAME <u>Zora V Swisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577 42 6474</u>	
17. INFORMANT <u>Robert C Stewart</u>		Address <u>E Riverdale, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> 660.5 DUE TO (b) <u>Term pregnancy & Caesarian section</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>4/7</u> , 19 <u>59</u> , to <u>11/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>59</u> , and that death occurred at <u>11:00</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Julius Kauffman</u>		ADDRESS (Street, city or town, state) <u>5102 Annapolis Rd. Bladensburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr Julius Kauffman, M.D.</u>		DATE SIGNED <u>11/4/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
1901

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

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PLACE OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12913

CERTIFICATE OF DEATH

12927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leroy Middle Andrew Last Stickley		4. DATE OF DEATH Nov. Month 20 Day 19 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-05
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector of Materials		10b. KIND OF BUSINESS OR INDUSTRY US Weapons Center	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gabriel Stickley		14. MOTHER'S MAIDEN NAME Ida Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Peacetime		16. SOCIAL SECURITY NO. None	
17. INFORMANT Agnes L. Stickley		Address 4017 Madison St. Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Enlargement of the liver with severe fatty degeneration, Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 18 , 19 59 , to Nov. 20 , 19 59 , that I last saw the deceased alive on Nov. 20 , 19 59 , and that death occurred on 10:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ronald S. Fleischer M.D.		ADDRESS (Street, city or town, state) 5932 Greensboro Rd. Md. DATE SIGNED 11/24/59	
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/23/1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR NOV 24 '59 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

13013

CERTIFICATE OF DEATH

13013

First Name

First Name

Second Name

Second Name

Third Name

Third Name

Sex

Sex

Sex

Sex

Sex

Age

Age

Year

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12928
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Laurel			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 352 Main Street				d. STREET ADDRESS 352 Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Wilhelmine Reinilde Stumpf				4. DATE OF DEATH Month Day Year November 11 1959				
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-14-12		
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Germany		11. BIRTHPLACE (State or foreign country) Germany		
12. CITIZEN OF WHAT COUNTRY? Germany								
13. FATHER'S NAME Ferdinand Hammer				14. MOTHER'S MAIDEN NAME Marie Kempf				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Karl Stumpf; same address		17. INFORMANT Address Karl Stumpf; same address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous intracerebral Hemorrhage DUE TO (b) Cerebral hypertension Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Cardiovascular renal disease								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.								
ACTUAL SIGNATURE <i>John T. Maloney</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED November 11, 1959		
EXAMINER'S NAME (Type) John T. Maloney, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/59		22c. NAME OF CEMETERY OR CREMATORY Garner Memorial Park		22d. LOCATION (City, town, or county) (State) Mount Airy Md		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dr. W. T. Donaldson</i>				ADDRESS Laurel, Md		24a. REC'D BY REGISTRAR DATE NOV 18 '59		
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>								

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH MAY 14 1968	
AGE 35 years		SEX Male	
RACE White		EDUCATION High School Graduate	
OCCUPATION None		MARRIAGE Single	
PLACE OF BIRTH Memphis, Tennessee		PLACE OF DEATH Baltimore, Maryland	
DATE OF BIRTH April 22, 1933		DATE OF DEATH May 14, 1968	
TIME OF DEATH 11:00 AM		PLACE OF DEATH Room 101, Federal Bureau of Investigation Building	
CAUSE OF DEATH Suicide by gunshot		MANNER OF DEATH Homicide	
DETAILS OF DEATH The deceased was found in Room 101 of the Federal Bureau of Investigation Building, Baltimore, Maryland, on May 14, 1968, at approximately 11:00 AM. He was lying on the floor, facing away from the entrance, with a gunshot wound to the back of the head. The wound was approximately 1 inch in diameter and was located about 2 inches above the occipital protuberance. The bullet entered the skull and exited through the base of the skull. The deceased was wearing a light-colored shirt and dark trousers. He was alone in the room at the time of his death.		FINDINGS The body was found in Room 101 of the Federal Bureau of Investigation Building, Baltimore, Maryland, on May 14, 1968, at approximately 11:00 AM. The body was lying on the floor, facing away from the entrance, with a gunshot wound to the back of the head. The wound was approximately 1 inch in diameter and was located about 2 inches above the occipital protuberance. The bullet entered the skull and exited through the base of the skull. The deceased was wearing a light-colored shirt and dark trousers. He was alone in the room at the time of his death.	
SIGNATURE OF MEDICAL EXAMINER J. Edgar Hoover		DATE May 14, 1968	
TITLE Director, Federal Bureau of Investigation		PLACE Washington, D.C.	

1

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14087

12915

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>6835 Annapolis Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alexander Francis Sutherland</u>				4. DATE OF DEATH Month Day Year <u>November 23 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>3-26-13</u>		9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book binder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>G.P.O.</u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Walter Sutherland</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Fey</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or if yes, give war or dates of service) <u>Yes 803-91-61 U.S. Navy</u>			
16. SOCIAL SECURITY NO. <u>011-09-5876</u>				17. INFORMANT <u>Ruth E. Sutherland; same address as # 2.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral compression</u> DUE TO (b) <u>Intracerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation 11/24/59</u>		22b. DATE THEREOF <u>11/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Conway Funeral Home</u>			
22d. LOCATION (City, town, or county) (State) <u>Peabody Massachusetts</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. REC'D BY REGISTRAR <u>NOV 25 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		24c. ADDRESS <u>Hyattsville, Md.</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar, far to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		1923		St. Louis, Mo.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Medical History		Previous Illnesses		Family History		Social History		Habitual Habits	
Hypertension		None		None		None		None	
Autopsy		Postmortem		Burial		Disposition		Remarks	
Yes		Yes		Yes		Yes		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness	
J. H. Smith		D. E. Jones		A. B. White		C. D. Green		F. G. Brown	
Date		Time		Place		City		State	
1923		10:00 AM		St. Louis		Missouri		U.S.A.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12929

12916

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				f. STREET ADDRESS 6509 Colesville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Arthur Last Taylor				4. DATE OF DEATH Month November Day 9 Year 19 59			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-19-13	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 4 Days 6		IF UNDER 24 HRS. Hours 6 Min. 46			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor				10b. KIND OF BUSINESS OR INDUSTRY G.P.O. Field Serv.		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert Taylor				14. MOTHER'S MAIDEN NAME Nellie Padgett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.E. 2		17. INFORMANT Address Cicelia Taylor; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary and cerebral edema 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Acute congestive heart failure DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 10, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 13, 1959		22c. NAME OF CEMETERY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR NOV 16 1959	
						24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1908

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		Jan 15, 1908	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St.		Teacher		Heart Disease		Natural	
City		County		Hospital		Physician	
Baltimore		Anne Arundel		St. Mary's		Dr. Smith	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Certificate		Place of Certificate		Office of Certificate	
Jan 16, 1908		10:00 AM		Baltimore		State Department of Health	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12917 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No.

12930

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Island Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gertrude</u> First <u>Elizabeth</u> Middle <u>Troy</u> Last				4. DATE OF DEATH Month <u>Nov.</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 15, 1877</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>59</u>	IF UNDER 24 HRS. Months <u>6</u> Days <u>19</u> Hours <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>	
13. FATHER'S NAME <u>Augustus Berkeley</u>				14. MOTHER'S MAIDEN NAME <u>Mary E Horstham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Son, John W Troy</u> Address <u>854 N. Lebanon Arlington, VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Intestinal Obstruction</u> <u>570.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mesenteric Thrombosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>5</u> p. m. 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 29, 1959</u> , to <u>Nov. 1, 1959</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>59</u> , and that death occurred at <u>5:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theo Zegarra, M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>4408 Queenway Rd Riverdale, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Theodore Zegarra, M.D.</u>				DATE SIGNED <u>11-1-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Pt. Geo Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u> ADDRESS <u>5801 Cleveland Ave Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G253 12/4/59 iwk

12931

12918

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hospital</u>				d. STREET ADDRESS <u>1620 Z Carrollton Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anne</u> Middle <u>Elizabeth</u> Last <u>Turner</u>				4. DATE OF DEATH Month <u>11</u> Day <u>-26</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-6-910 1880</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Run Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horace A. Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Julia Athey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Hospital Record (Miss Eunice Turner) Daughter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Edema of brain</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma (adenoma) of Stomach</u> DUE TO (c) <u>lycan</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-30</u> , 19 <u>59</u> , to <u>11-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-25</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Wilkinson</u>				ADDRESS (Street, city or town, state) <u>Riverdale Md</u>			
PHYSICIAN'S NAME (Type) <u>R Wilkinson</u>				DATE SIGNED <u>Nov 26, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 28, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Burtonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle A. Last VanHorn		4. DATE OF DEATH Month Nov. Day 3 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-79
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min.	11. IF UNDER 24 HRS. Months 80 Days 80 Hours 80 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Lowther		14. MOTHER'S MAIDEN NAME Amanda Burton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Gladys Eubank-daughter-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis(Left internal Capsule) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 22 , 19 59 , to Nov. 3 , 19 59 , that I last saw the deceased alive on Nov. 3 , 19 59 , and that death occurred at 1:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3101 ARUNDEL RD. DATE SIGNED ACTUAL SIGNATURE John M. Grassgreen M.D. MT. RAINIER, MD. PHYSICIAN'S NAME (Type) Dr. Grassgreen			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 11/6/59		22b. DATE THEREOF 11/6/59	
22c. NAME OF CEMETERY OR CREMATORY Grove Cemetery		22d. LOCATION (City, town, or county) (State) Doddridge Co. W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		24a. REC'D BY REGISTRAR NOV 5 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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THE UNIVERSITY OF CHICAGO PRESS

1990

1. *Journal of the American Medical Association*, 1997; 277: 1033-1038.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12920

CERTIFICATE OF DEATH

12934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Brentwood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 North Brentwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4506 41st Avenue				d. STREET ADDRESS 4506 41st Avenue			
3. NAME OF DECEASED (Type or print) First Martha Middle J. Last Wallace				4. DATE OF DEATH Month 11 Day 9 Year 1959			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/1874		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 11 Days 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Otha Johnson			
14. MOTHER'S MAIDEN NAME Elizabeth --				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Otelia Muggs Address 1207 48th St., N. E., D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 11 Day 9 Year 1959 Hour a. m. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hyattsville, Md.	
20f. (City or town) Hyattsville, Md.				20g. (County) Prince Georges Co., MD.			
21. I certify that I attended the deceased from Nov 9, 1957 to Nov 9, 1959 , that I last saw the deceased alive on 11-9-59 , and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leonard Hays				ADDRESS (Street, city or town, state) 5201 Balto. Ave., Hyattsville, Maryland			
PHYSICIAN'S NAME (Type) Leonard Hays				DATE SIGNED Nov 11-1-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/59		22c. NAME OF CEMETERY OR CREMATORY Carver Memo Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. [unclear]				24a. REC'D BY REGISTRAR DATE NOV 12 '59		24b. REGISTRAR'S SIGNATURE Carlton S. [unclear]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12935

Reg. Dist. No.

12921

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pi. Geo</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>209</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmount Heights</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges San Hosp</u>			d. STREET ADDRESS <u>6107- R. Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Eula Mae White</u>			4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1918</u>		9. AGE (In years last birthday) <u>41</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Zolacco farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Zolacco</u>		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13. FATHER'S NAME <u>Bud Walters</u>		
14. MOTHER'S MAIDEN NAME <u>Cinnahelle Watson</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT Address <u>Clarence Young, 6107 R. St., Wt.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gente congestive heart failure</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hepatic failure</u> (a), stating the underlying cause last. (c) <u>Cirrhosis of the liver</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Washington, D.C.</u>	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Nov-7-1959</u>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhinehart & Co. 3015-12th St.</u>		ADDRESS <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Harris</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

12936

12922

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 30 Min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 7828 Piedmont Ave.							
3. NAME OF DECEASED (Type or print) Baby Girl Williams				4. DATE OF DEATH Nov. 3, 1959			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 3, 1959	
9. AGE (In years lost birthday) 30		10. IF UNDER 1 YEAR 30		11. IF UNDER 24 HRS. 30		12. CITIZEN OF WHAT COUNTRY? 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
13. FATHER'S NAME Ernest J. Williams				14. MOTHER'S MAIDEN NAME Florence Clayborne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. Mother			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) Intellectual DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 3, 1959 , to Nov. 3, 1959 , that I last saw the deceased alive on Nov. 3, 1959 , and that death occurred at 6:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. John Perkins M.D.				ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville, Md. DATE SIGNED 11/4/59			
PHYSICIAN'S NAME (Type) Dr. John Perkins M.D.				5301 Hamilton St. Hyattsville			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION				22b. DATE THEREOF 11/9/59			
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator.				24a. REC'D BY REGISTRAR NOV 13 '59			
24b. REGISTRAR'S SIGNATURE Carlton S. K...							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12380

CERTIFICATE OF DEATH

1900

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF DECEASED

NAME OF SURVIVOR

NAME OF WITNESS

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF MINISTER

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF CHURCH

NAME OF MINISTER

NAME OF WITNESS

NAME OF SURVIVOR

NAME OF DECEASED

NAME OF SURVIVOR

NAME OF WITNESS

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NAME OF SURVIVOR

NAME OF WITNESS

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <u>District of Columbia</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Germ Dale</u>		c. LENGTH OF STAY IN lb <u>3 Mo</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47x-3</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Germ Dale Hospital</u>		e. STREET ADDRESS <u>60 Q St NE</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Howard</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept 1, 1922</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>21</u> Hours <u>19</u> Min.	11. IF UNDER 24 HRS. Months <u>3</u> Days <u>21</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Messenger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Internal Revenue</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Howard Williams</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hampton Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1-43 to 2-46</u>		16. SOCIAL SECURITY NO. <u>1-43 to 2-46</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Right, Postoperative</u> DUE TO (b) <u>Pulmonary Tuberculosis</u> DUE TO (c) <u>lying cause lost.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>23 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left Upper Lobectomy 10-5-59; Left Thoracoplasty 11-18-59</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/21</u> , 19 <u>59</u> , to <u>11/21</u> , 19 <u>59</u> that I last saw the deceased alive on <u>11/21</u> , 19 <u>59</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John T. Steward</u> M.D.		ADDRESS (Street, city or town, state) <u>GLENN DALE HOSP.</u> DATE SIGNED <u>11/21/59</u>	
PHYSICIAN'S NAME (Type) <u>MOE WEISS, M.D.</u>		<u>GLENN DALE, Md.</u>	
22a. BURIAL, CREMATION, REMOVA (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>11/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Steward</u> ADDRESS <u>3rd St NE</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>C. L. S. King</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15097

CERTIFICATE OF DEATH

1922



[Faint, mostly illegible handwritten text on a lined form, likely containing death record details.]



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12859

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. LENGTH OF STAY IN 1b <u>16</u> <u>Mt. Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4218-34th Street</u>		d. STREET ADDRESS <u>14218-34th Street</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>H.</u> Middle <u>Holfe</u> Last		4. DATE OF DEATH <u>Nov. 9th</u> 19 <u>59</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 20, 1881</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool maker, Ret. Navy Yard, D.C.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Louis Holfe</u>		14. MOTHER'S MAIDEN NAME <u>Mary Catherine Gaffey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-40-5925</u>	
17. INFORMANT <u>Pansy Irene Holfe - wife</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Anteroselectic Heart Disease with coronary occlusion (Sept. 5) and terminal congestive heart failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and terminal congestive heart failure.</u> DUE TO (c) <u>Failure.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 4</u> , 19 <u>56</u> , to <u>Nov. 9</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>Nov. 9</u> , 19 <u>59</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Furze</u>		ADDRESS (Street, city or town, state) <u>1746-K St. N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Walter D. C.</u>		DATE SIGNED <u>4/9/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/12/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u>		ADDRESS <u>Mt. Rainier, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 12 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraws</u>	

15038

CERTIFICATE OF DEATH

15038

[Faint, illegible text, likely bleed-through from the reverse side of the document. The text appears to be a narrative or medical report.]